...ne for Change in the Blue Cross Movement

...Public Must Pay for Nursing Education

...nds Behind the Trends in Architecture

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An answer that raises a question

Youngsters can quickly settle the question as to who is the "bigger." The more subtle question, "Am I as 'big' as I ought to be?" is more difficult to answer.

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This Month

WE INTRODUCE....

Thomas H. Creighton learned about architecture from Harvard and about hospitals from Goldwater. As a Harvard graduate with several years' experience as a practicing architect, he entered the New York Department of Hospitals in 1939, when Dr. Goldwater was commissioner, as assistant senior architect. With Isadore Rosenfield, chief architect, he worked in the research, planning and design phases of a vast program of modernization and new construction.

During the war, Mr. Creighton returned to private practice and designed a number of army, navy, coast guard and maritime service hospitals.

A year ago, Mr. Creighton became editor of *Progressive Architecture*. His continued interest in hospitals is indicated by the hospital features which have appeared in that magazine and by the paper which appears on page 50 of this one.

Dr. Norman Q. Brill's conviction that psychiatry belongs in the general hospital comes from experience—in military and civilian hospitals and in private practice as a neuropsychiatrist. For three years after entering service in 1941 he was chief of the neuropsychiatric service of the station hospital at Fort Bragg; then he was moved to the surgeon general's office, where he served for the remainder of the war in the neuropsychiatry consultants' division. On this assignment he visited many hospitals, both here and abroad, and had an opportunity to observe the practice of psychiatry in general hospitals.

As assistant chief of the neuropsychiatry division of the Veterans Administration today, he is again in a position to observe the advantages of bringing psychiatry into the community general hospital. As a practicing psychiatrist in the District of Columbia and a professor of neurology at Georgetown University, he sees a need for increased community psychiatric facilities and deplores the fact that "the psychiatric emergency, unlike the surgical emergency, must be exposed to jail, court and often formal commitment before being hospitalized and treated." For details, turn to page 56.

Gordon Davis, whose analysis of the Blue Cross movement appears on page 43 of this issue, has been doing public relations work in the hospital field for five years, from 1942 until last September as assistant director in charge of public relations of Michigan Hospital Service, and since then as a public relations consultant in the field. Mr. Davis came to hospital work from the science desk of a newspaper, having been science editor of the *Cleveland Press* for several years prior to his Blue Cross connection in Michigan. Of his earlier newspaper career with the *Press* and the *Buffalo Times,* he says, "It covered the usual range: police beat, courts, general assignment, feature, radio editor, automobile editor, aviation editor, editorial writer." He is a graduate in journalism of the University of Michigan.

"Accountants have a rather dull existence," **Charles G. Roswell** said in reply to our inquiry about his background. "As a matter of fact," he added, "I could relate far more interesting stories about my dog than I could about myself."

Mr. Roswell didn't tell us anything more about his dog, but here is the fill-in on himself: He was graduated from Pace Institute, New York, in 1928 and went on to St. John's University to take his B.S. degree in economics in 1934. The same year, he was licensed as a certified public accountant. Then he went to St. John's Law School, receiving the LL.B. degree in 1938.

Mr. Roswell entered the hospital field through the auditor's office, doing hospital audits and system installations for a firm of public accountants for several years, then serving as comptroller and assistant director of St. Luke's Hospital, New York. Since 1940, he has been assistant director and consultant on hospital accounting for the United Hospital Fund of New York.

Nell Robinson, R.N., is superintendent of the East Liverpool City Hospital, East Liverpool, Ohio, and an active member of state and national hospital and nursing organizations. She came to East Liverpool in 1929 from West Virginia, where she had been a nursing and hospital executive for several years following graduation from the Ohio Valley Hospital nursing school. Miss Robinson also studied at Columbia and Kent universities and attended the Chicago institute for hospital administrators.

In East Liverpool, Miss Robinson's interests outside her profession include the Federation of Women's Clubs, of which she is vice president, the D.A.R., and active participation in a literary group. She is the author of an article published recently in the *West Virginia Review,* based on research in the history of Tomlinson Run State Park.

Dr. A. P. Merrill, superintendent of the Home for Incurables, a 450 bed chronic disease hospital in New York City, has been a frequent contributor to The MODERN HOSPITAL, winning the Gold Medal Award in 1945 for his article on suspect nurseries. Coming from a family of physicians, Dr. Merrill studied medicine at Stanford University and was well on the way to a career in surgery when the opportunity came which made him a hospital executive instead. For a time he combined private practice with administration at the San Francisco County Hospital. In 1940, he moved to St. Luke's Hospital, Chicago, as medical director—a full time administrative post in which he remained for five years before going to his present hospital in New York two years ago.

THE ROVING REPORTER

First, the Reading Clinic

Maybe they're poor readers, the nursing school students who flunk out.

Acting on that hunch, Hackensack Hospital School of Nursing, Hackensack, N. J., started in 1940 to require poor readers to remove this deficiency at the Reading Clinic, which is a branch of New York University.

The poor reading ability of applicants to the nursing school shows up in the entrance examinations prepared by the National League of Nursing Education which give a general picture of the capacity of each applicant. If the prospective student lacks the ability to read with comprehension, even if she has a high I.Q., off she must go to the Reading Clinic before she can enroll. She pays for this training herself. Out of a September class of 55, for example, 21 students were asked to take the course.

Marie A. Wooders, R.N., principal of the school, is more convinced each year of the value of this prerequisite of reading comprehension. It cuts down the drops-outs considerably.

Not Little Anesthesia Brown

A Missouri child has the correct name on her birth certificate thanks to the intelligence of a medical record librarian. This MRL was checking birth certificates before mailing them to the bureau of vital statistics when she was stopped cold by the name Anesthesia Brown. Her early amusement turned to incredulity as she read further: "Female. Mother's Name: Christina Poppas; Mother's Birthplace: Athens, Greece."

What, asked the medical record librarian of herself, is the Greek name that sounds like Anesthesia? Why, Anastasia, naturally. She telephoned the supervisor of the maternity floor and asked her to investigate the name of the baby. Sure enough, it was Anastasia.

The Mail Goes Through

Patients are fewer but mail is heavy around the holidays, but in any hospital of size the handling of mail is a task at any time of year.

Recently, Evanston Hospital, Evanston, Ill., a 244 bed institution, reorganized its mail service, creating a new department housed in its own room. This department relieves the bookkeeping staff and greatly speeds up mail delivery.

Over the mail room, which has been cheerfully decorated, Mrs. Betty Blanchard presides. Assisting her is a crew of well trained volunteers who distribute the incoming mail. Letters are sorted and marked for destinations so that a practical route can be followed. Deliveries to patients and to the various departments are made twice a day.

Special delivery service is made to one department on certain parcel post packages. If the box is small and perforated, Mrs. Blanchard has learned that it probably contains a live frog so someone trots off to the nursing school with this laboratory teaching aid.

Neighborliness by Radio

At 73, Mrs. Eva Viseur of Christian County, Illinois, had reason to be grateful to neighbors in four midwestern states. After thirteen months in the hospital with a fractured hip, she wrote to Radio Station WLS:

"During my convalescence I was placed on a fracture bed that had been

given the hospital by the WLS Christmas Neighbors Club. At a later stage, when I felt better, I used a wheelchair also donated by club members. Then I was graduated to a walker, a gift from the clubbers, and now I am learning to walk all over again."

For the last eleven years this Chicago radio station has during the month of December accepted the nickels and dimes and dollars of its listeners who wished to become members of its Christmas Neighbors Club. Last year's take was $33,625; this year it will probably be more when the totals are available for publication.

The fund goes in its entirety to hospitals, orphanages and child care institutions. Every hospital in the four states gets a questionnaire in the autumn listing the gifts to be distributed and asking the superintendent to mark his first, second, third, fourth, fifth and sixth choices. He is also asked to suggest other suitable gifts for hospitalized children or adults which can be added to next year's list.

This year's list of gifts includes table model radios and radio-phonographs, wheelchairs, orthopedic walkers, infant incubators and fracture beds. Four hundred hospitals and orphanages will benefit from the fund.

"Dear Sir, You Cur"

Why, when writing to that old fee splitter, Dr. Hazzard, or to Mr. Aiken Head, who is likely to come to board meetings with a hangover, or to Mrs. Arrears or to the numerous issue of Auntie Bond, should a hospital keep on addressing them as "dear" just because the tradition of business correspondence calls for it? Why not just drop the "dear" and say: "Doctor Hazzard: Again it has been called to our attention that. . . ."

For a dollar you can join the Society for Abolishing "Dear" in Business Letters (111 East Delaware Place, Chicago II, Ill.) and emancipate yourself. For the dollar you get 360 stamps like the one shown. Just stick the special stamp on the body of your business letter and Mrs. Arrears will see for herself why no tone of endearment is used in addressing her.

The idea behind the society is to take the note of insincerity out of business letters and reserve the term of affection for friends who are really dear to you.

Oscar Pays a Debt

Oscar was a miser but at his death the entire estate went to Children's Hospital, San Francisco. Oscar died of a stomach-ache, induced by his hobby of swallowing pennies, nickels, dimes, quarters and street car tokens.

Postmortem examination revealed the cause of Oscar's death. It also yielded coinage weighing 3 pounds 4 ounces.

The California Academy of Science presented Oscar's estate to the Children's Hospital, the total being $7.54.

Oscar, it should be added, was a seal. Oscar also, it was found at necrospy proceedings, was a lady.

Baby Guessing Contest

A baby guessing contest is something new and different (as far as we know) in hospital publicity. Yonkers General Hospital, Yonkers, N. Y., won considerable local publicity for itself recently by announcing a contest for the closest guess of the number of babies born in its maternity department since the hospital's inception in 1896. Guesses ranged all the way from 8793 to 15,000.

Mrs. Mary Burgoyne of Yonkers won the contest with her guess of 15,000 but even Mrs. Burgoyne was on the conservative side, since between 1896 and the close of last year the hospital has welcomed into the world 19,833 newborn infants.

The contest was one publicity idea employed by the hospital in its 50th anniversary celebration.

READER OPINION

Wants Back Issues

Sirs:

For a great many years our Mary Johnston Hospital in Manila, P.I., subscribed to your magazine. We kept these in our files for the use of our student nurses. During the years of the war we were prevented from obtaining them.

Our hospital was burned during the time of the Japanese occupation and most of the library of the school of nursing and hospital was destroyed. Plans are being made to rebuild this just as soon as possible. Classes of nurses are being conducted at the present time in connection with other hospitals.

Each issue of your magazine contains very valuable information and there are certain volumes we are very anxious to obtain. These are the following years: 1940-1946. These could be sent directly to Bertha Odee, 431 P. Paredes, Manila, P.I., who is carrying on the work there as superintendent of nurses.

I wonder if it would not be possible for you to put an appeal in your magazine for these numbers we need. No doubt people subscribing to the magazine would be willing to send a number or two to us in the Philippines, if they knew our need for them.

Mary L. Beam

Because of heavy demands for back issues, we are unable to supply those needed at Mary Johnston Hospital. We hope some of our readers will respond to this appeal for help.—ED.

Reasons for Crowding

Sirs:

The hospitals in Southwestern Ohio and Northern Kentucky are crowded. For some time, it has been necessary to have waiting lists in most of these hospitals for elective surgery and, in effect, to ration beds. The length of time such deferred cases have to wait may be as much as several weeks in some hospitals and several days in others. The chief causes of this situation in my opinion are:

Realization on the part of the general public that it can and will receive a better type of medical care in a hospital.

Ability to pay for hospital care by the public generally.

Increasing insistence by the physician for admission of patients who heretofore might have been cared for at home.

Utilization during the first year of membership in various types of hospital insurance. Our studies indicate that in communities where Blue Cross enrollment is high and where the members have been enrolled for more than one year the incidence of hospitalization of Blue Cross members is lower than that of the unenrolled general public.

Shortages of nurses and other hospital personnel complicate the problem, since certain hospitals in our area have had to close off parts of their buildings because of lack of personnel.

In my opinion this community does not need new hospitals but rather certain additions to present hospital facilities. . . . Shortly we will have half the total population enrolled in Blue Cross. If we can enroll 100 per cent of the population and get by the first year of utilization . . . I doubt that we would need many more beds than we now have. All our studies indicate that our patients go sooner to the hospital than those not enrolled, stay on an average two days less and have . . . fewer recurrent admissions. To say that Blue Cross members will eventually solve the hospital bed shortage problem may sound somewhat astounding, but I think we can prove that point.

James E. Stuart
Hospital Care Corporation
Cincinnati

Hughes' Hospital Bed

Sirs:

The Howard Hughes story (The MODERN HOSPITAL, September, p. 128) was a bit of fine publicity but bore no relation to what actually happened. Hughes did obtain a bed, sent it to the factory and had it fixed up as described. After he tried it, however, he went right back to his standard hospital bed and wouldn't use the one he'd had fixed up at all.

ALDEN B. MILLS
Administrator
Huntington Memorial Hospital
Pasadena, Calif.

Captions Switched

Sirs:

Somehow the legends for figures 3 and 4 ("Designed for Premature Living," The MODERN HOSPITAL, August 1946, pp. 49-51) have been published in reverse order, giving rise to inaccuracies which perhaps are hardly fair to the incubator companies concerned. The legend appearing under figure 4 belongs with figure 3 and that under figure 3 with figure 4.

Janet B. Hardy, M.D.
Johns Hopkins Hospital
Baltimore

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

On Building a Hospital

Question: What information can you give us on the building and maintenance of a 15 or 20 bed hospital for our city?—L.L.P., Calif.

ANSWER: The Commission on Hospital Care has been cooperating with state hospital survey groups in making a thorough inventory of all health and hospital facilities in every state in the country. The object is to work out a master hospital plan for each state so that this country will have some sense and reason in its hospital building and expansion program.

The California study is well along. If you will get in touch with Dr. P. K. Gilman, director of the California Hospital Survey, 760 Market Street, San Francisco 2, he will be able to inform you how your project will fit into the master California hospital plan. Such information is essential before you can intelligently plan the type or size of the hospital to be built.—E. W. JONES.

Discipline for Staff Members

Question: What should be done when members of the medical staff persistently refuse to obey the rules and regulations, such as writing clinical records, attending clinical conferences and observing the rules of quarantine and aseptic technic?—L.S., Iowa.

ANSWER: The answer to this question depends upon whether or not the offending group is in the majority. If it is in the minority the staff should, through the board, take steps to help eliminate such members from the staff. If the offenders are in the majority, certain regulatory bodies, such as the state health department, American College of Surgeons and A.M.A., should be used to remedy this situation.—ROGER W. DEBUSK, M.D.

Training for Administration

Question: Is the apprenticeship or preceptorship method of training for hospital administration acceptable?—E.C., Ind.

ANSWER: Obviously, the apprenticeship or preceptorship method of training for hospital administration is highly acceptable under appropriate circumstance. When one reviews the number of outstanding administrators, including many presidents of the American Hospital Association, who received their training by the apprenticeship method it is apparent that this method has been highly useful in training men of ability. On the other hand, many people have taken apprenticeships but have not attained any real distinction in the hospital field.

Apparently the value of the apprenticeship depends upon two factors: (1) the apprentice and (2) the teacher. If the apprentice is good material to begin with, has a sincere desire to master hospital administration and has a reasonably good background in at least some of the fields of learning that comprise hospital administration, a big hurdle has already been cleared. However, even a good apprentice cannot get good training unless the training is offered by someone who has a broad conception of hospital administration, a keen understanding of the entire field and the willingness and time to devote to training.

Men like Heywood, Bluestone, MacLean, Munger, Buerki, Carter and many others have turned out excellent apprentices. Doubtless this method will continue to be used even though more and more people who want training in hospital administration will first take organized university courses.—ALDEN B. MILLS.

No Specimens, No Patients

Question: What should be done with a doctor who refuses to let the hospital have pathological specimens removed at operations?—S.M., Ark.

ANSWER: He should be denied the privilege of bringing patients to the hospital.—ROGER W. DEBUSK, M.D.

Personnel Manager Needed

Question: Is a personnel manager necessary and advantageous in all hospitals of 200 beds and over? How would you handle personnel problems in a hospital of less than 200 beds?—N.K., Ohio.

ANSWER: A personnel manager is certainly advantageous in all hospitals of 200 beds and over, although, since there is no personnel manager in my own institution of slightly over 200 beds, I know that one is not absolutely necessary. The hospital can function but it means that a great deal of the personnel work has to be shouldered by the administrator and the various department heads, personnel work is not done as well or thoroughly as it might be and there are other losses that would be avoidable with a competent personnel administrator.

In a hospital of less than 200 beds the hospital administrator, his secretary, the pay roll secretary or someone must undertake the responsibility of seeing applicants for employment and referring them to the proper department head for interview. Often, the department heads will administer the personnel policies of the institution as determined by the board in consultation with the administrator. The matter of orienting and training employes must be done by the department heads or their assistants and a great deal of their time is necessarily involved in such procedure.

It is difficult in a hospital of nearly 200 beds that does not have a personnel manager to do all of the things that constitute good personnel work. For example, exit interviews with employes who are leaving, particularly in these days of high turnover, would take so much time that they are often omitted. Job descriptions, job analyses, job grading and the preparation of salary scales based upon this previous work are more difficult to accomplish in a hospital that does not have a personnel manager. Often, such things are omitted entirely.

A few hospitals have been able to obtain volunteers who would undertake to do personnel work. At one time, Wesley Memorial Hospital in Chicago had such a man, and an outstanding job was done by another volunteer at Queen's Hospital in Honolulu. Whether other hospitals could find people to do personnel work on a volunteer basis would be determinable only after study. If that is the only way it can be done, it is worth exploring.—ALDEN B. MILLS.

Keep Staff Conferences Lively

Question: What is the best way to stimulate and keep up attendance at medical staff conferences?—M.J., Minn.

ANSWER: Attendance at medical staff conferences is directly proportional to the excellence of the program. In both urban and rural communities it is possible to augment the conference material with an occasional discussion led by a well known physician or outstanding teacher.—ROGER W. DEBUSK, M.D.

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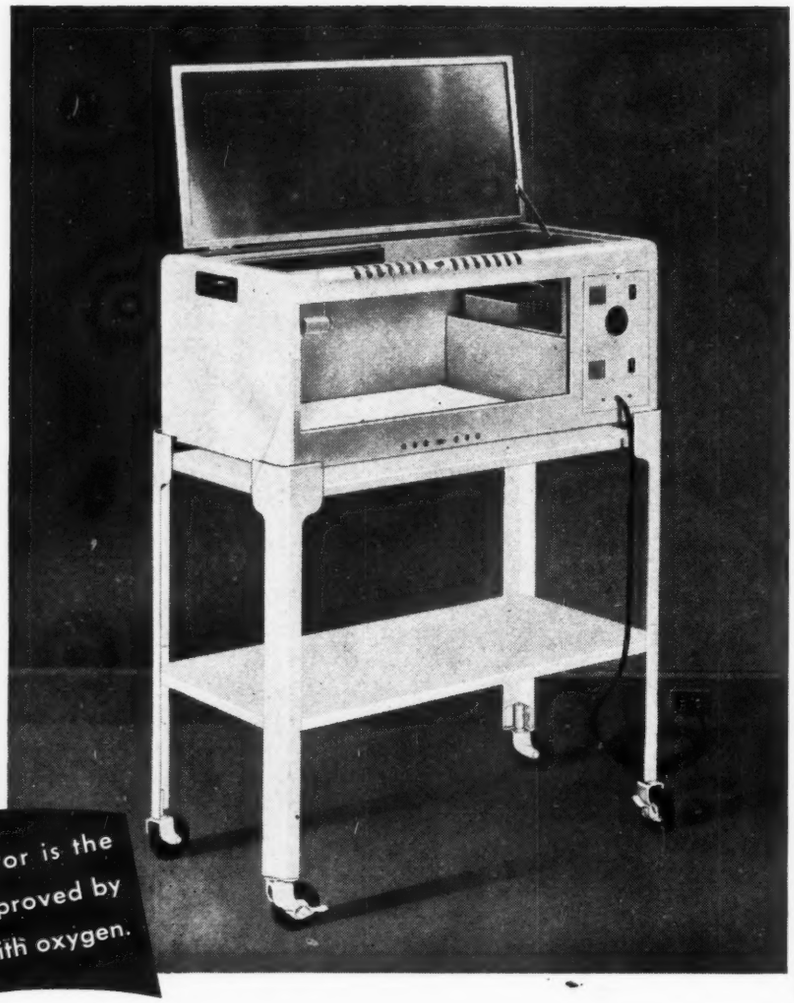

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LOOKING FORWARD

Resume Speed

NEGOTIATIONS between publication printers and the typographical union in Chicago have now been concluded. This will enable The MODERN HOSPITAL to return to its regular publication schedule during the coming months.

Group Practice in Hospitals

BY THE sheer logic of events, a new form of medical practice is winning a place for itself in the organization of our medical resources. In the opinion of many qualified experts, group practice will reach its greatest usefulness in the shortest possible time if group practice units are integrated into existing hospital facilities and staffs.[1]

When Blue Cross began to capture the imagination of hospital workers, it may have seemed too slow in taking root for those who were far-seeing. But the early opponents who, like Jim Jay, "got stuck fast in yesterday" have long ago been won over, and the idea is now part of our way of life in this country. The method of self help in trying times proved to be preferable to the alternative which would necessarily have been imposed from above by a government handout.

Although Blue Cross has dealt successfully with only one segment of the problem, it has given us a demonstration of a method which can now lead the hospital economist into wider pastures. Mutual aid, in which neighboring people threatened by a common enemy divide the cost of dealing with him, is the highest manifestation of the philanthropic spirit among men. The Blue Cross organizations which exhibit this characteristic are here to stay, and we are now ready for the next step.

The progressive increase of consultation service and the consequent increase of consultation cost, on an individual-fee basis in private practice, have the effect of limiting the best medical care to only a few. The poor man who, in his distress, goes shopping from dispensary to dispensary is moved by a desire for a group opinion, even though he does it unintelligently and unproductively. This pooling of medical effort on a comprehensive basis is as much a group phenomenon in the area of medical relief as is the method of group insurance in the area of financial relief. As a further advantage of group insured, group medical care, we have medical coverage at all times no matter where the beneficiary may be located—in his home, in the outpatient department or in the hospital.

Comprehensive medical coverage on a voluntary basis regardless of the time or place of illness, contracted for in advance by the well tried method of spreading the cost, is the next step which experience and clear vision prescribe. Under this new plan the patient is benefited further because his doctor steps from the privacy of confinement in his office into the light which is reflected in many ways by an assemblage of his colleagues, who join with him in competing for therapeutic results. Doctors are forever talking shop; the group medical clinic is the best sounding board for their conversation.

One cannot find fault with the enthusiast who goes so far as to urge that the future hospital be planned around such a sound nucleus as this. Hospitals are group medical units; it remains only to reorganize them in accordance with this new manifestation of scientific philanthropy. Anyone who has listened to Dr. Dean A. Clark, medical director of the Health Insurance Plan of New York City, need seek no farther for inspiration on this subject in hospital planning. While his efforts must, for the moment, be directed largely toward the organization of independent group medical units, he also has agreement from at least one great American hospital to the extension of its activities into the home, in addition to its hospital and outpatient service, as a demonstration project bearing all the benefits of the Health Insurance Plan as a full, prepaid medical service.

Group practice will bring the practitioner closer to the hospital and both will benefit by the association. The hospital world in general, and the medical world in particular, will do well to support and to apply the principles of the Health Insurance Plan to which Dr. Clark and his co-workers are so earnestly drawing our attention.

Appointment in Chicago

APPOINTMENT of a man lacking professional qualifications in hospital administration as warden of Cook County Hospital, Chicago, one of the largest institutions in the world, is another demonstration of the fact that politics and hospitals can't be mixed. The appointment has been publicly deplored by, among

[1] See "The Trend Toward Group Practice," by Henry B. Makover, M.D., Mod. Hosp. 67:86 (November) 1946.

others, representatives of the American College of Surgeons, the American Medical Association and the Chicago Hospital Council.

The appointment has been defended by the newly elected president of the Cook County board of commissioners on the ground that the appointee was an able, experienced hotel manager who had also supervised construction of a number of office buildings. This is unquestionably true. The appointee may also be a good husband and father, a fine moral character, a great horseback rider and a keen student of eighteenth century Dutch paintings. These are all admirable qualities, but they have nothing to do with hospital administration.

The fact is that the new warden, whatever his qualifications of character, personality and ability, has had no training or experience specifically to equip him for one of the nation's most exacting professional positions. What is needed for hospital responsibilities is, as Plato has defined the difference, "not virtue, but some certain virtue."

Judging from the number of public officeholders and hospital trustees who apparently subscribe to it, the misconception that anybody who can run a hotel can run a hospital is still widespread. Unfortunately, the truth will have to be learned at the expense of the sick.

Beware the Slicker

IT IS a well known fact that rackets of all kinds have flourished since the war ended. Full purses are an invitation and a challenge to sharpsters, who have developed any number of ingenious new ways to relieve the unwary of their cash.

Now comes evidence that gullible or incautious hospital administrators are being taken in by a sales swindle featuring a switch from familiar, branded merchandise to an inferior product. The administrator orders an accepted brand from a "new representative" of a known and trusted company and later receives a shipment of unlabeled goods, billed by an unknown firm. Many times a tip-off on the switch is this approach by the slick salesman: "My company has a present for you"—accompanied by the free offer of an expensive pen and pencil set, an electric clock or some other elaborate premium.

Whatever their good intentions, hospital administrators and purchasing agents who are victimized in such swindles are failing their responsibility to conserve hospital resources. Here are a few simple rules of purchasing procedure which may save the hospital money, time and embarrassment in these days of burgeoning rackets:

1. Refuse all personal gifts offered as an inducement to purchase. Reputable companies do not need to, and do not, use any such bait to attract orders.

2. If you don't know the name of the company, investigate before you place an order.

3. If an unknown salesman calls on you representing a company you know, ask for identification. It is customary among most firms to notify hospitals of changes in sales personnel; you are perfectly justified in asking for credentials when no such notice has appeared. Reputable salesmen will always have identification and gladly furnish it.

4. Make sure you know the brand you are ordering. Sometimes a name closely and cleverly approximating a familiar brand is used, so that actual misrepresentation is avoided.

5. If you have already ordered merchandise which is not as specified on arrival, send it back—along with any gift you may have accepted from the salesman. Then notify the Chamber of Commerce or Better Business Bureau in your town. Only publicity will eliminate these swindles and keep others from being victimized.

Personal Relations

ONE of the nation's great industrial corporations has recently completed an exhaustive study aimed at determining the factor or factors which contribute most to worker productivity. In this study, it is reported, all the incentives commonly considered important were carefully analyzed and measured among various groups of workers in company plants over a period of several years.

Among the many factors studied were earnings, incentive systems, working hours, surroundings, recreation periods, vacations, security, recognition, promotions and many others. None of these was found to be the most important ingredient of worker motivation. Workers who are most productive of all, the study demonstrated, *are those who like or admire their fellow workers and boss.* The average worker will put forth his greatest energy and resourcefulness to get results for a group he thinks is regular and a boss whose knowledge and skill he admires, and the worker responds with something less than his greatest effort to all other inducements.

Of course, this should not be interpreted to mean that adequate pay, security and all the other modern conditions of employment are not important. The history of personnel relations in industry, including hospitals, proves that they are important. But the present study emphasizes that the core of personnel relations is still human relations; there is no substitute for the fine human feeling of friendship.

To know whether or not he is the kind of person his employes like and admire, the boss must look deep within himself; the answer is not to be found in textbooks. The best yardstick has been in use for two thousand years; affection and respect are earned according as men and women abide in thought and manner and deed by one great precept: *Therefore all things whatsoever ye would that men should do unto you, do ye even so unto them.*

THE BLUE CROSS NEEDS CHANGE

GORDON DAVIS
Birmingham, Mich.

FOR all its spectacular pyramiding of enrollment and despite the respect which it now commands in the national scene, the Blue Cross movement today is far from being in the best of health. It is disturbed by rumblings of dissension; it is beginning to meet true competition, and it has encountered serious problems for which no remedies, or only stop-gap remedies, have been found.

Increasingly, it becomes imperative that there be coldly analytical examination of both Blue Cross and hospital interests in it, nor can any good purpose be served by pretending that all is well in this field. The ultimate fate of Blue Cross hangs in the balance while hospitals and plans argue out problems of payment for Blue Cross services, of control of Blue Cross management, of national integration and of relationships with allied professions.

The answers to these problems will determine whether Blue Cross is to continue to grow and prosper, as it should and indeed as it *must,* or is to slip into that state of relative ineffectuality which invites public action to serve the purposes Blue Cross is intended to serve.

Blue Cross has come a long way because of the rightness *and the timeliness* of its basic concept. As Prof. Floyd Armstrong has said, there is nothing so irresistible as an idea whose time has come.

Emphasis Is on Timeliness

Unlike many in the Blue Cross or hospital fields, I am inclined to place more emphasis on the timeliness of the idea than on the details of its physiognomy. Basically, the idea is that of a system which enables average families to "pay in advance" for hospital care, which distributes costs so that no one family is unduly burdened and which operates at low overhead. It seems logical to inquire whether Blue Cross features beyond this basic idea are anything more than mere window dressing.

Take such aspects of Blue Cross as nonprofit organization and hospital sponsorship. Plans make considerable capital of these features and, admittedly, they are excellent sales points, but there are many profit-making businesses which do a better job than some nonprofit Blue Cross plans do and there have been instances in which hospital sponsorship has been more of a liability than an asset. Nevertheless, as a whole, I believe these to be highly desirable attributes which should by all means be retained. My purpose in challenging them is to indicate the importance of proper perspective. Preoccupation with ornaments rather than fundamentals already has led in some instances to efforts to repair the roof while the foundation collapsed.

In some such renegade mood, let us examine the most pressing of the current hospital-Blue Cross controversies: that of Blue Cross methods of payment to hospitals. At present the plans pay hospitals on the basis of a predetermined rate per patient day, on the basis of the hospitals' regular charges to the public, or on the basis of the hospitals' operating costs (and no one yet has figured out exactly what items ought to be included in those costs). Endless, acrimonious arguments have characterized endeavors to decide which method is "right." In some cases these arguments have flared into headlines and outright conflicts, and hospitals, plans and Blue Cross subscribers have suffered unnecessarily as a result.

Truly enough, this controversy has been accentuated by inflation, but the cause is of little importance. Blue Cross, if it is to endure, must so operate that its hospital payments either are not affected by, or adjust almost automatically to, fluctuations in the national economy.

Method Must Be Accepted by All

It should have become apparent that no payment method can survive unless it is acceptable not simply to a good majority of the hospitals but to *all* of them. That situation which places hospitals and plans on opposite sides of the bargaining table is an unhappy one at best. The contracts for service thus effected cause discontent to the extent that either party is compelled to yield and resentment and dissension from the moment that enforcement becomes necessary. Nor does it square with

the concept of public service or of free choice of hospitals to penalize the subscriber who goes to a hospital, either within his own plan area or outside it, which is not a "member" or "participating" institution.

In token recognition of the latter point, Blue Cross plans have tried to forward what seems to me a cumbersome and unrealistic arrangement. This is the so-called "reciprocity" program by which subscribers to one plan are entitled to service benefits in the member hospitals of other plans provided reciprocity agreements are in effect with other plans. With some 85 Blue Cross entities each offering different sets of benefits and with reciprocity arrangements effective among some and not among others, the farther this program goes the more complicated it becomes.

What all this means, in my opinion, is that payment of hospitals on any basis other than their regular charges to the public has been demonstrated to be unworkable. Reasoning that there should be concessions to persons who prepay their hospital bills through the hospital's own program for the purpose, high minded leaders in both the hospital field and Blue Cross have been reluctant to accept this conclusion. The choice is that always difficult one between idealism and practical necessity.

Others Will Follow Suit

Many Blue Cross plans already have made the choice in favor of necessity. I consider it inevitable that all others ultimately will follow suit. If it is accepted that the lesser ideal, that involving method of payments to hospitals, is obscuring the greater, that of Blue Cross progress as an instrument of public service, then undue effort to avoid this very real issue can result only in harm to Blue Cross.

Needless to say, the manner in which hospitals are paid is equally of vital interest to the people, since the people must pay the freight. I am beginning to question whether Blue Cross plans are sufficiently sensitive to the wants of the public. Within Blue Cross there has been a certain evangelical zeal which, in at least some of its major characteristics, is indistinguishable from that of the social planners who would saddle us with compulsory governmental health insurance.

This attitude stresses not what the people want but what in the planners' opinion is good for them. It tries to standardize; it refuses to recognize the extreme importance of local variations from the master pattern.

Too often, for example, we concede to the proponents of governmental medicine the point that the people must soon have complete protection against all the costs of sickness. What if the people don't want it at the price they will have to pay? There is excellent evidence that today they do not.

Objective Remains the Same

Inflation has temporarily dampened the Blue Cross drive for payment of the complete hospital bill in all cases, but the objective is by no means relinquished. It is, in fact, a splendid objective and, properly controlled, it becomes a manifestation of leadership and farsightedness. It is shortsighted, however, when it is pressed to the point of coercion. In the long run, neither the public nor employers can be compelled by a voluntary agency to accept more protection than they want.

This is one of the genuine advantages of voluntary programs. They are flexible. They quickly reflect the desires of the people, for if they do not, they are supplanted by others which are more elastic. They cannot be regimented because regimentation means rapid loss of public favor.

What I am suggesting is that Blue Cross plans have reached the point at which they are going to have to give the people broader options. One all inclusive subscriber contract, offered at a standard rate sufficient to cover widely varying conditions and costs of hospital care, affords no choice at all. Even two or three contracts may not be sufficient. The people have the right to decide for themselves whether they want or can use a Ford, a Dodge, a Buick or a Cadillac. They may indeed want to know that they will have nothing further to pay should they require hospitalization wherever they may go to obtain it. On the other hand, they may prefer protection limited to the major expenses or to the probable costs in the particular hospitals they are most likely to use.

What would this do to the Blue Cross service concept? Certainly, it need not destroy it. Full service should continue to be at once the objective and the impetus of Blue Cross. There is, however, a wide variation in the subscriber rates that must be charged for benefits covering all hospital services in all hospitals and for benefits limited to the commonest services in the hospitals customarily patronized by the subscriber group in question.

While the corollaries to the foregoing conclusions are perhaps too involved for detailing here, I do not believe them to be paradoxical. A limited service contract obviously implies a ceiling on Blue Cross payments to hospitals. The purpose of the ceiling should not be to restrict service, however, but to enable the lowest possible subscriber rates covering the specified services in representative hospitals of the community to which the particular subscriber group belongs. The same payments up to the ceiling should be made to other hospitals either in or outside the community. In contrast with this is the present practice whereby subscribers in low cost hospital areas often subsidize the care of other subscribers in higher cost hospital areas, or whereby most subscribers unfortunate enough to be hospitalized outside their own plan area do not receive the services to which they are entitled by virtue of the rates they have paid.

Problems Can Be Solved

It is obvious that any change in the Blue Cross approach is going to entail certain disadvantages. Some such changes as those suggested here would run into various legal, administrative, competitive and other problems, but Blue Cross has encountered and solved far more serious problems in the past.

Is something like this the answer? I do not know. There is bound to be a great deal of trial and error in any change of method. A far more detached point of view, a greater reliance on practical considerations and perhaps a little less flagwaving seem to me essential if Blue Cross is to arrive at that vigorous and flourishing maturity which is the condition of its permanence.

It is my conviction that Blue Cross has hampered itself by too rigid adherence to certain ideas that have almost become fetishes. These ideas served an excellent purpose in the

early stages of Blue Cross, but the usefulness of at least some of them now has been largely outlived.

One idea that recent developments have reopened to question is that of hospital control of Blue Cross. As an abstract idea, I believe this to be wholly commendable and proper. Certainly, Blue Cross should never be opened to commercial exploitation any more than hospital care should be, but there have been some disturbing, if fortunately isolated, indications of hospital attempts to exploit Blue Cross. For the good of the people whom both Blue Cross and hospitals equally are designed to serve, there must be safeguards both ways.

Blue Cross Is a Business

At the risk of inciting vigorous denunciation, I would make a further point. The operation of a Blue Cross plan bears almost no resemblance to the operation of a hospital. While a Blue Cross plan is nonprofit, it nonetheless is a business organization competing with business organizations. Often the attitudes soundly applied to the administration of a hospital simply do not work when applied to a Blue Cross plan, and it is a difficult matter for a hospital administrator sitting on a Blue Cross board to keep this considerable divergency in mind.

The question of Blue Cross salaries is another delicate consideration. It is an anomaly for the executive director of a large Blue Cross plan, the employe, to receive a salary that may be twice that of some of the members of his board of trustees, the employers. Some of the director's chief assistants may even be paid more than some board members. These trustees would not be human if occasionally some of them were not secretly covetous or resentful of the Blue Cross executives' incomes.

Even so, the executive directors of Blue Cross plans often are paid much less than they could command at comparable positions in commercial insurance companies. Competent Blue Cross leaders certainly do not stay with Blue Cross because of the financial rewards they receive, but because of devotion to the ideals of the movement they represent. This has been one of the remarkable characteristics of Blue Cross; it has attracted leaders of great ability because of its humanitarian aspects.

Part of the difficulty, in my opinion, is not that Blue Cross executives are overpaid, but that hospital administrators are underpaid. There is a growing awareness that the field of hospital administration must offer greater financial inducements to attract and keep the best talent, but time will be required before this realization takes concrete form by fattening the pay envelope.

Meanwhile, the question of who is to control Blue Cross awaits answer, and it does not seem that the answer should be difficult in principle. If it is conceded that Blue Cross alone is only partial protection and that it should be accompanied by medical or at least surgical protection—and certainly every dictate of reason and experience justifies this assumption—then it is only logical that Blue Cross boards should exhibit equal representation of hospitals and the medical profession.

Few laymen can see any justification for separate organizations selling protection against hospital and medical expenses. The two go together as naturally as ham and eggs, and arbitrary divorcement of them leaves the public palate dangerously dissatisfied.

They Can Get Along

Again, there are ancient and human reasons for endeavoring to separate the inseparable, and the rivalry and sometimes suspicion which exist between the medical profession and the hospitals will not be eliminated overnight. The obvious answer is to create a situation in which the two must live together, each with equal rights. Where this already has been done, perhaps the fur has flown picturesquely at times but, generally speaking, each school has discovered an amazing humanness and much to esteem in the other. The result: Everybody gains.

I am one of those who believe further that Blue Cross plans should be adequately representative of the communities they serve. That is the democratic way, and Blue Cross is strictly and admirably a democratic institution. It is quite possible for closed groups to get so wrapped up in self interest that they do not sufficiently consider the prior claims of the society they serve. Undoubtedly, it means headaches for Blue Cross boards if they admit the public—representatives of industry, labor, business and agriculture—to their panels, and yet these headaches might well be more symptomatic of growing pains than of ill health.

The community served by Blue Cross is not local; it is national. At present, however, Blue Cross is far from being a national movement except to a certain limited extent by sufferance of the 80-odd wholly autonomous plans. By way of illustration, certain Blue Cross leaders have tried for years to develop a uniform subscriber contract that would be acceptable to all plans, but their progress in this direction has been lamentably slow and sometimes sadly unsupported.

Contracts Are Too Varied

It is something of a miracle of salesmanship that has induced a number of national employers to enroll their employes in Blue Cross. Such employers may have to deal with two or three dozen different subscriber contracts offering benefits that in some cases are exceptionally comprehensive and in others, grossly unsatisfactory.

Fortunate indeed that there was a time when Blue Cross executives could console themselves by saying that, as bad as Blue Cross might be in some individual instances, it still was better than anything else in the field. That time is rapidly vanishing. Regular insurance is beginning to develop policies that offer true competition, and this is good.

I have serious doubts about the ability of Blue Cross to meet this situation without a radical change in its attack on the problem. It is plain ostrich tactics to insist that employers, large or small, are so sold on the idea of Blue Cross that they will stick to it regardless of the inconvenience to themselves, the unfairness to their employes in some localities and the lure of definitely competitive protection in the commercial field. At its present rate of adaptation, Blue Cross is preparing for nothing better than locking the door after the horse is stolen.

To take the glum view, everything has been tried and Blue Cross may as well accept the idea that, in the long run, it will be impossible for it to keep much of its national scope. I am, in fact, convinced that individual plans should devote much more time and effort to expansion of enrollment in local groups—em-

ployed, rural, community and other. Enrollment of big national groups is pleasurable, but it also is volatile; there need to be many groups of counterbalancing stability.

In developing a truly unified national program, however, Blue Cross is a long way from exhausting all possibilities. A sort of Blue Cross "constitutional convention" to draft a tighter and more effective federation might be worthy of consideration. Certainly, the present national organization is a Topsy-like creation, and no one seems to have any truly accurate idea of just what its functions ought to be. Because of the way in which Blue Cross developed, it was clearly impossible to proceed nationally according to well defined plans. It seems that now is the time to halt the indiscriminate addition of wings to the original structure and to call in the architects with a single and definite assignment to redesign.

This Is Not Apostasy

I do not feel that the submission of suggestions such as these is in the nature of apostasy. Many Blue Cross plans now place cash limitations on the amount of the liability they assume under their subscriber contracts. Many now pay hospitals on the basis of the hospitals' regular charges to the public. Many offer subscribers a choice of contracts. Many are only figuratively controlled by the hospitals. A number are jointly controlled by the hospitals and the medical profession, and a number have achieved true community representation on their boards. In fact, this essay is little more than a review of Blue Cross developments that gradually are becoming well entrenched but that still seem to be considered as somehow degrading or unworthy.

Surely, it is significant that some of the most successful plans have adjusted their operations to practical necessities and, surely, Blue Cross cannot help but benefit by recognizing the facts of life and taking vigorous action accordingly. The world is full of schemes and ideas that have soared into immense popularity through sheer novelty. Democracy itself is such an idea. But the wreckage of those which failed to adjust rapidly enough to society-as-it-is already is buried beneath the sands of time. Blue Cross should ponder seriously the object lesson in that fact.

They Make Blindness an Asset

AT THE Philadelphia Naval Hospital they have discovered that blinded men need ask no quarter from sighted men in darkroom developing of x-ray films.

In September 1944, when the war had drained off the nation's manpower, the hospital dental department faced a shortage of trained technicians for the x-ray developing room. An able young oral surgeon, Comdr. Roger G. Gerry, thought, "Since this work is done in virtual darkness, why couldn't one of our blinded patients do it as well as a person who can see—maybe eventually better?"

The Naval Hospital staff said, "Let's find out." So, from several candidates who tried preliminary training, they selected Louis H. Schilt, of Ozone Park, N. Y.,—picked him, just as any employer might in filling a job, because he was quick-learning, skillful, ambitious—and in six weeks Louis was a first rate technician.

Soon Louis broke in another blinded veteran, Wallace H. Campbell, of Catlettsburg, Ky. Then Campbell taught Leonard G. Homa, and the chain training system subsequently turned out other first class technicians. Some of them now have nice jobs based on their newly acquired skill.

Technically, the story of how these darkroom experts function is complicated. Briefly, they rely on a simple, inexpensive stamping of Braille identification on film racks, and corresponding marks on small spring clips which are attached to the envelopes until the developed, fixed, washed and dried films are returned to them. Timing is done by an open-faced Braille clock; the alarm rings when the films should be removed from developer or fixer tanks, but if for any reason it doesn't the sensitive blinded person is capable of telling the right time practically to the tick anyway.

Temperature of the developing solutions is vitally important. Braille thermometers cannot be placed in the liquid; so they are dipped in inside copper tanks. If water gets in the tank the thermometer goes awry. No matter. Most blind technicians can tell by touch almost exactly what the temperature is.

The trained worker prepares his own solutions, and when the day's work is done, he tidies up the darkroom, leaving it scrupulously shipshape. Most of the newly blinded men learn the technic faster than a sighted person can; some become so adept that while doing a fine job at processing films they shave themselves, shine their shoes or read Braille books. One taught darkroom technics to a class of sighted x-ray students.

The Blind Are More Careful

The hospital authorities hope that gradually civilian hospitals, laboratories and commercial photographers all across the country will recognize the skill of blinded technicians in darkrooms. The tendency of potential employers naturally is to ask, "But don't the men make mistakes?" Of course—though mostly when learning. So do sighted people, who are usually more careless.

One day Commander Gerry found that a technician had ruined some films by forgetting to cover the darkroom window. He got mad and gave the technician an artistic bawling out. Then, to his horror, he remembered that the man was blind. He was very much relieved when the technician exclaimed happily, "I won't do it again. That's the first time anybody has bawled me out since I was blinded. Thank you, sir. Now I feel like a real guy again."

Practical nurse students receive forty-five hours of instruction in homemaking theory and practice.

It's a Practical Solution of the Nursing Shortage

A. ROSENBERG
Administrator
Hospital for Joint Diseases, New York City

IN COMPANY with other hospitals throughout the country, the Hospital for Joint Diseases, New York City, experienced an acute shortage of nursing personnel during the war years. The end of hostilities brought no relief and what to do to alleviate this condition gave us no end of worry. Intensive thought and study finally convinced us that we should embark upon a new venture, that of establishing a school of practical nursing.

To this end, we made a survey of the hospital's physical facilities and as a result selected one floor of the main building for the school. The floor area was reconstructed to provide a classroom for 30 students; a demonstration ward of 10 beds; a home economics laboratory to accommodate 12 students at one session; a library-study room large enough for at least half of each class; an office for the principal, and an office for the secretary and instructors. All of these rooms were equipped and furnished as shown in the accompanying floor plan and check list.

The nursing committees of the board of trustees and the medical board and the administration of the hospital then proceeded to: (1) establish a curriculum, (2) set up standards of eligibility for selection of students, (3) appoint a faculty, (4) recruit students and (5) apply to the New York State Department of Education for approval of the school. In so doing, the following steps were taken:

Curriculum: A curriculum was outlined to fit specific requirements of practical nursing training to cover a twelve months' period. The year was divided into two major divisions, *i.e.* "Theory," three months, and "Clinical Assignments," nine months.

Classroom Theory, Three Months

Subjects		*Hours*
Care of self		12
Behavior, working relationships and elementary psychology		12
Housekeeping		
Class	18 hours	42
Laboratory	24 hours	
Food and cooking		
Class	15 hours	45
Laboratory	30 hours	
Normal structure and function of the body		30
Elementary nursing: class and laboratory		150
Common diseases		12
Care of mother and newborn infant		8
Care of children		9
Care of convalescent, chronic and aged		7
First aid and bandaging		24
Total		351

Clinical Assignments, Nine Months

One month: Female medical
One month: Male medical
One month: Female surgical
One month: Male surgical
Two months: Maternity care, newborn-nursery, formula room
One month: Pediatrics
One month: Orthopedics
Two weeks: Vacation
Two weeks: Distributed among physical therapy, occupational therapy, diet kitchen and tray service

Standards of Eligibility: The following eligibility requirements for students were formulated:

1. Women between 18 and 50 years of age, who are American citizens or have declared their intention to become citizens; good physical and mental health; record of good behavior; acceptable personality and aptitude; minimum of eight years of elementary school. (Although not required, two thirds of the students admitted have had from two to four years of high school.)
2. References from at least two persons, including a schoolteacher.
3. Complete physical examination of student, including chest x-ray and blood test. (It might be mentioned here that students receive free medical and hospital care throughout the twelve months' course and one week of sick leave which, if not used, is given as a premium at the end of the school year.) In addition, a vacation of two weeks is granted.

CHECK LIST OF FURNITURE AND EQUIPMENT FOR SCHOOL

Office of Director of Nurses
1 desk
1 swivel chair
12 armchairs
2 straight back chairs
1 table
1 table lamp
1 desk lamp
1 electric fan
1 wastepaper basket
1 bookcase

Nursing School Office
1 typewriter desk
2 flat top desks
2 armchairs
3 straight back chairs
1 secretarial chair
1 four drawer file cabinet
3 one drawer files (small)
1 scale
1 bookcase
3 desk lamps
2 wastepaper baskets

Classroom
30 chairs with writing arms
1 table
1 straight chair
1 blackboard
1 demonstration bed
1 teacher's table
1 skeleton with cabinet

Utility Room
1 bedpan washer
1 sink
1 utility table
1 straight back chair
4 built-in utility cupboards
1 garbage can
1 stepladder
1 hamper
1 utensil sterilizer
1 instrument sterilizer
1 gas or electric burner

Demonstration Ward for 10 Pupils
10 regular hospital beds
10 springs
10 mattresses
1 child's bed
1 child's spring
1 child's mattress
1 teacher's table
1 straight back chair
10 bedside tables
10 bedside chairs
10 bedside pitchers with glasses
1 bed screen
10 bedpans

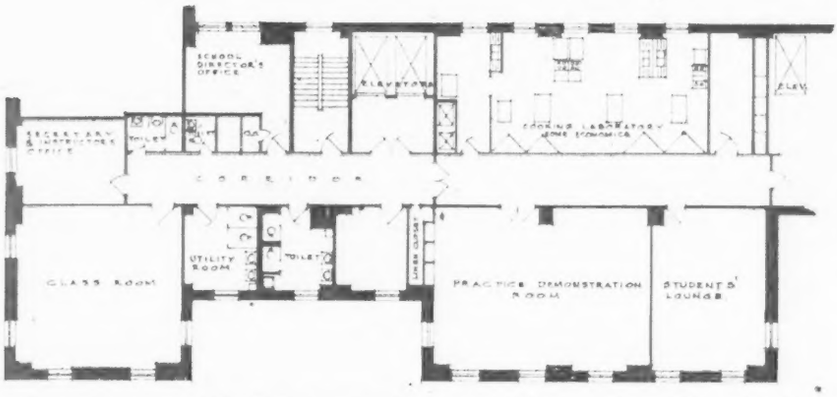
Linen Closet
Ample linen for three complete sets:
1 set of linen for made-up beds
1 set of linen for change of laundry
1 set of linen for reserve

Library—Study Room
1 leather upholstered divan
1 leather upholstered large armchair
3 light-weight leather armchairs
2 writing tables
2 readers' tables
10 straight back chairs
1 phonograph
1 piano; 1 piano stool
3 floor lamps; 1 table lamp
1 end table
1 wastepaper basket
Book shelves along wall

HOME ECONOMICS LABORATORY

Large Equipment
3 double sink units with double drainboards
3 four burner gas ranges
3 table base cabinets
3 unpainted dining tables
12 unpainted chairs
6 wooden stools
1 small dishwashing machine
1 refrigerator

Small Equipment
3 heatproof baking dishes
3 orange squeezers
3 glass measuring cups
3 glass pint measures
9 aluminum measuring cups
12 heatproof custard cups
3 small coarse mesh strainers
3 small fine mesh strainers
3 pancake turners
3 pom tongs
9 sets measuring spoons
3 utility scoops
3 serving spoons; 3 wooden spoons
3 potato mashers
3 rolling pins
3 egg beaters
6 utility trays
3 wooden chopping boards
6 asbestos mats
3 double boilers
3 nests of bowls (4)
3 casseroles
9 saucepans with lids
3 baking sheets
3 square cake tins
3 round layer cake tins
3 pie tins; 3 glass pie plates
3 large strainers
9 frying pans
3 dish pans
3 wire dish racks
6 soap dishes
3 utility jars
6 dish towels; 6 dish cloths
3 coffee makers
3 individual tea pots
12 table knives
24 table forks
12 bouillon spoons
12 dessert spoons
24 teaspoons
3 sets salt and pepper shakers
3 vegetable brushes
3 fruit scoops
3 spatulas
3 can openers
6 paring knives
9 pot holders
6 rubber sink stoppers
12 cereal bowls
12 sauce dishes
12 dinner plates
12 teacups
12 saucers
12 salad plates
12 bouillon cups with saucers
12 bread and butter plates
Supply of staple groceries



Opposite page: Ward demonstration room. Above: Plan of the school.

4. Full maintenance, books and uniforms are furnished and, in addition, a stipend of $15 a month is allowed each student. (There are no fees upon registration.)

Faculty: For a school with an established policy of admitting three classes a year, each class to have no more than 30 students, it was decided that the faculty should consist of: (a) director, (b) nursing arts instructor, (c) clinical supervisor, (d) home economics teacher, (e) secretary and (f) part time instructor in anatomy who would devote the better part of her time to the office of the main hospital nursing department.

Recruitment: Recruitment necessitated a publicity and public relations program which essentially consisted of preparation of a booklet describing the objectives of the school, posters placed in strategic locations in the community, addresses before senior high school classes, radio talks and announcements, news releases and newspaper advertisements.

As a result of these endeavors, by the time the first class was ready to be admitted in October 1945 we had received 134 inquiries concerning the course. An analysis of these inquiries showed that 89 came as a result of the radio advertisements and 45 from other sources. Although 43 were found to be eligible, only 18 were admitted to the first class. During the year, however, seven students dropped out for various reasons and 11 completed the full twelve months' course and were graduated in October 1946.

The experience in selecting the second class which matriculated in February 1946 was that 83 inquiries were received. Of this number, 25 were from our radio appeal, eight from newspaper advertisements and the remaining 50, from posters and through our enrolled students who recommended the course. Out of these, 25 students were admitted, five have dropped out and 20 now remain.

The recruitment of the third class admitted in September 1946 required practically no publicity. Obviously, the school had already gained in popularity and knowledge of it had spread by word of mouth inasmuch as 68 applications reached the school. Of these, 28 were admitted, two have dropped out and 26 now remain.

The school is now proceeding to recruit students for the fourth class to be admitted in February. There are already thirty applications in our files and more are expected in the next few months.

It may be of some further interest to record here additional analyses of the students of the first three classes.

Meeting State Requirements: The physical facilities, equipment, curriculum, standards of eligibility of students and qualifications of faculty had to meet the requirements of the board of nurse examiners of the New York State Department of Education. Accordingly, application was made to the state for approval of the school.

After careful inspection of all elements that entered into its organization, its physical facilities and its policies, a provisional approval was granted to the hospital by the state to be changed into a final approval after the first class had been graduated. It should be added here that the regulations of New York State provide for licensing a graduate as a "Practical Nurse in the State of New York" after she has completed an approved course from an approved school and passed a state examination.

In October 1946, we graduated the first class of 11 practical nurses with fitting ceremonies which were attended by the families and friends of all the students. We presented each graduate with a class pin and a graduation certificate enclosed in a leather case. Seven of the first class have decided to remain with the hospital as regular employes and we hope that a similar proportion of the second class will do the same after graduation in February.

Now that the hospital has had a full year of experience it may be concluded that a school of practical nursing is a contribution both to the community as a whole and to the hospital in particular. The general "tone" of our nursing department has been elevated, the shortage in nursing personnel has to a great measure been reduced and the nursing service to patients has been improved almost to the prewar level.

We feel that in the future the graduate nurse will continue to be necessary for highly professional care, for supervisory control and for certain procedures required by the physician. However, a large number of practices and procedures hitherto performed by the graduate nurse can well be performed by a person who has completed a well defined and approved twelve months' course especially designed for the purpose.

Analyses of Students in Three Practical Nursing Classes

Class	*Ages of Students*				*Race*			*Religion*			
	18-25	26-35	36-50	Total	White	Negro	Total	Prot.	Cath.	Jew.	Total
First	7	3	1	11	8	3	11	4	5	2	11
Second	12	4	4	20	14	6	20	8	9	3	20
Third	15	3	8	26	19	7	26	15	6	5	26

The Trends Behind the Trends in Hospital Design

THOMAS H. CREIGHTON

Editor
Progressive Architecture
New York City

THE first reason for noticeable trends in hospital design today is that accurate knowledge about the needs of hospitals is available to those who are going to design them. The second important factor is the changing attitude, on the part of those designers, toward the whole conception of architecture.

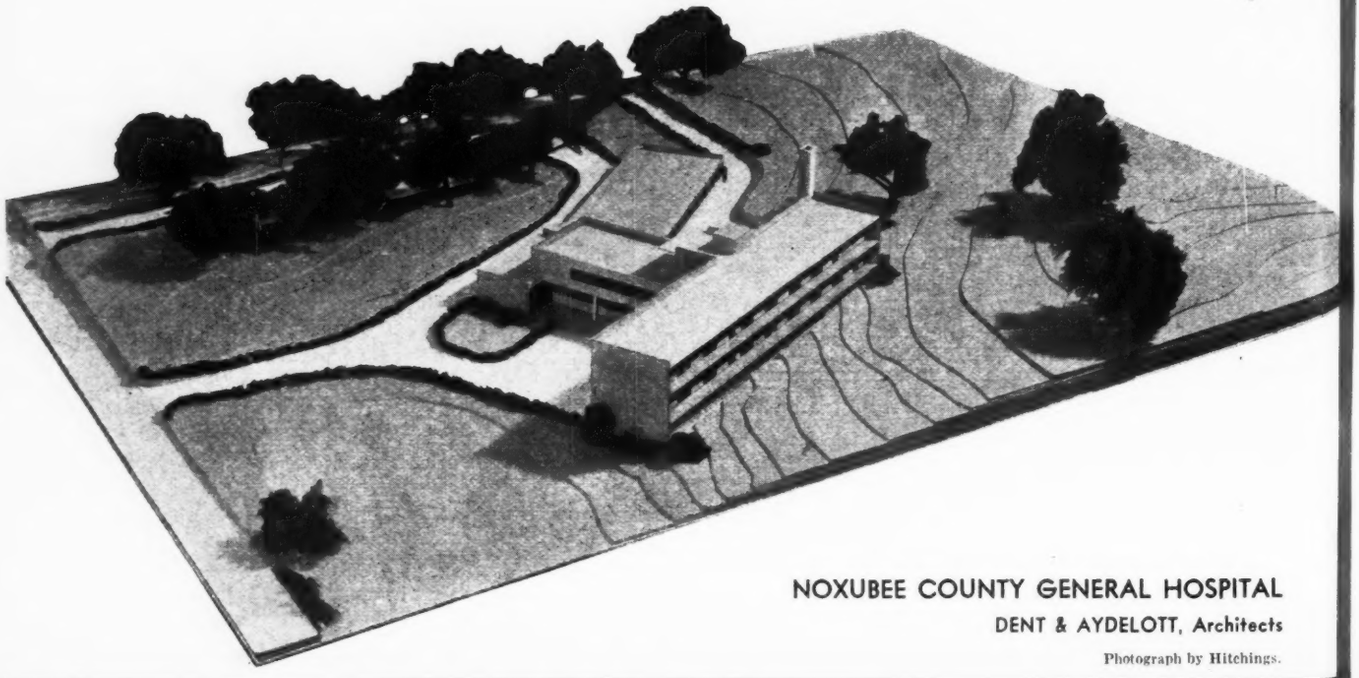
Modern architecture is a misunderstood term. When we speak of modern nursing methods, no one shudders and thinks the revolution is coming. Yet when we speak of modern architecture there is muttering about "that modernistic stuff," fear of importations from Europe or, at best, a mental image of another style which can be accepted or rejected along with Georgian or Gothic. Let's forget this business of using the classical orders or not using them. Let's forget "traditional" *v.* "modern" as a battle of styles. Let's forget for the moment, if we can, the innate feeling that a certain surface decoration may be appropriate to a given neighborhood and another, inappropriate.

Hospital administrators and architects are scientific people. We are concerned with basic things, and we can leave superficial mannerisms to the dilettantes who have no deeper interests. Judging the value of a hospital building by the correctness of the copying of moldings from Greek antiquity is comparable to judging a surgeon's abilities by his taste in neckties. There has been a basic change in achitectural thinking, and the fact that it coincides with a better knowledge of planning implications for hospital routines holds great promise for hospital architecture in the period ahead.

Architects had for so long forgotten what architecture is that it is no wonder their clients and the general public had been led astray. Architecture is simply the best possible design of facilities for some social purpose, using the materials and the technics at hand. We had become so used to imitating building forms developed for other purposes and materials which are no longer our main resources that our conception of design had become completely formalized.

Our tastes had become so jaded that we had lost our ability to judge architecture objectively, either as an art form or as a building form; we judged by clichés of imitation. A hospital in Indiana was a "good" building if it imitated well a New England Georgian style which had come from an English form based on an Italian Renaissance derived from

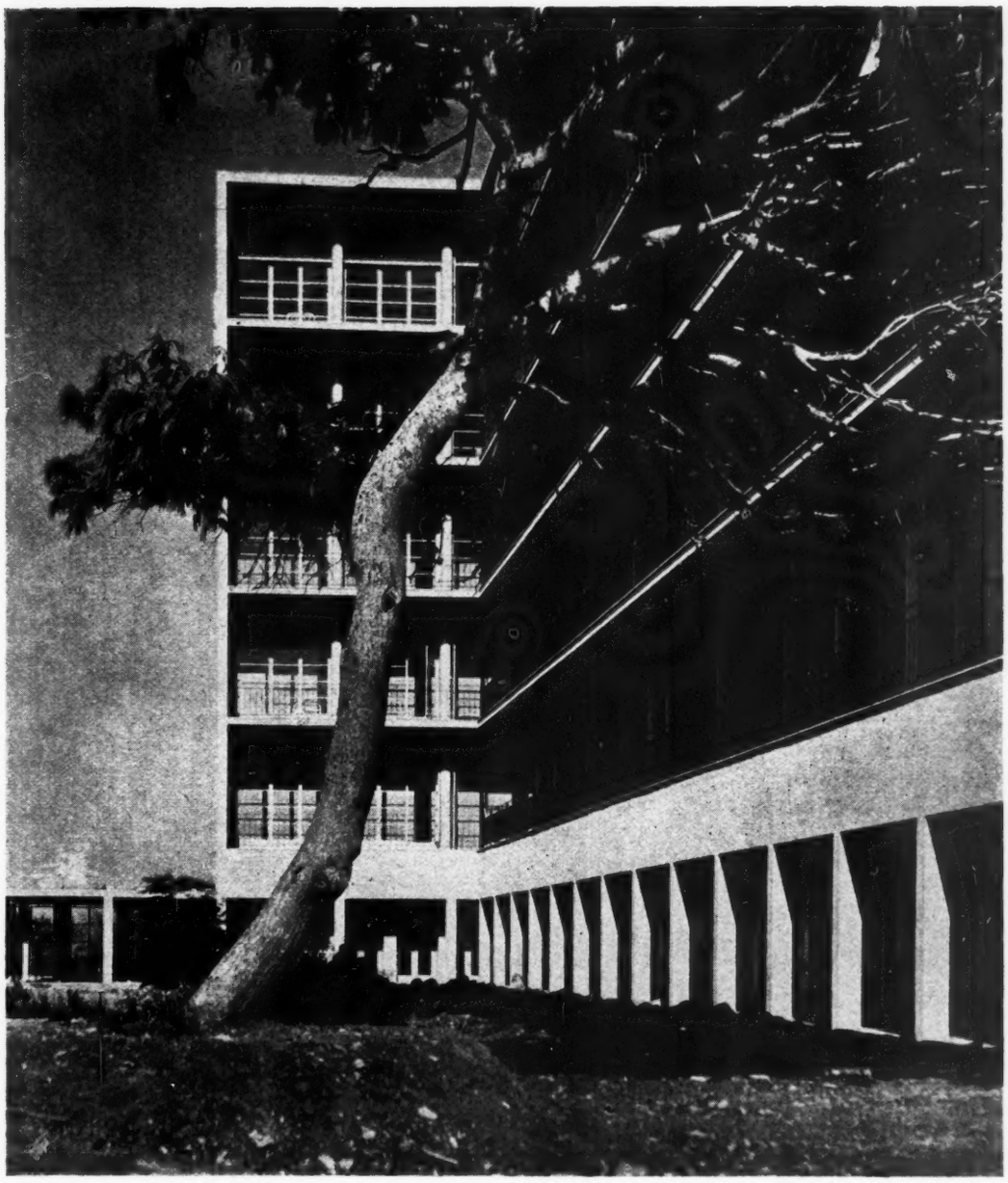
From a paper presented at the American Hospital Association convention, October 1946.



NOXUBEE COUNTY GENERAL HOSPITAL
DENT & AYDELOTT, Architects
Photograph by Hitchings.

GENERAL HOSPITAL HAIFA PALESTINE

ERIC MENDELSOHN
Architect



Photograph by Alfred Bernheim

The photographs reproduced on these pages (courtesy of "Progressive Architecture") illustrate some recent examples of modern hospital design.

the Roman Empire structures whose precedents were Greek temples. This is a far cry from providing useful space for modern therapies.

A recent magazine article discussed hospital planning in terms of shapes —the U shaped hospital, the T plan, the H scheme. These are conceptions based on restrictions and limitations that no longer exist. I have recently seen good hospital plans shaped like wagon wheels, like airplanes, like telegraph poles and like ballet dancers poised on one leg.

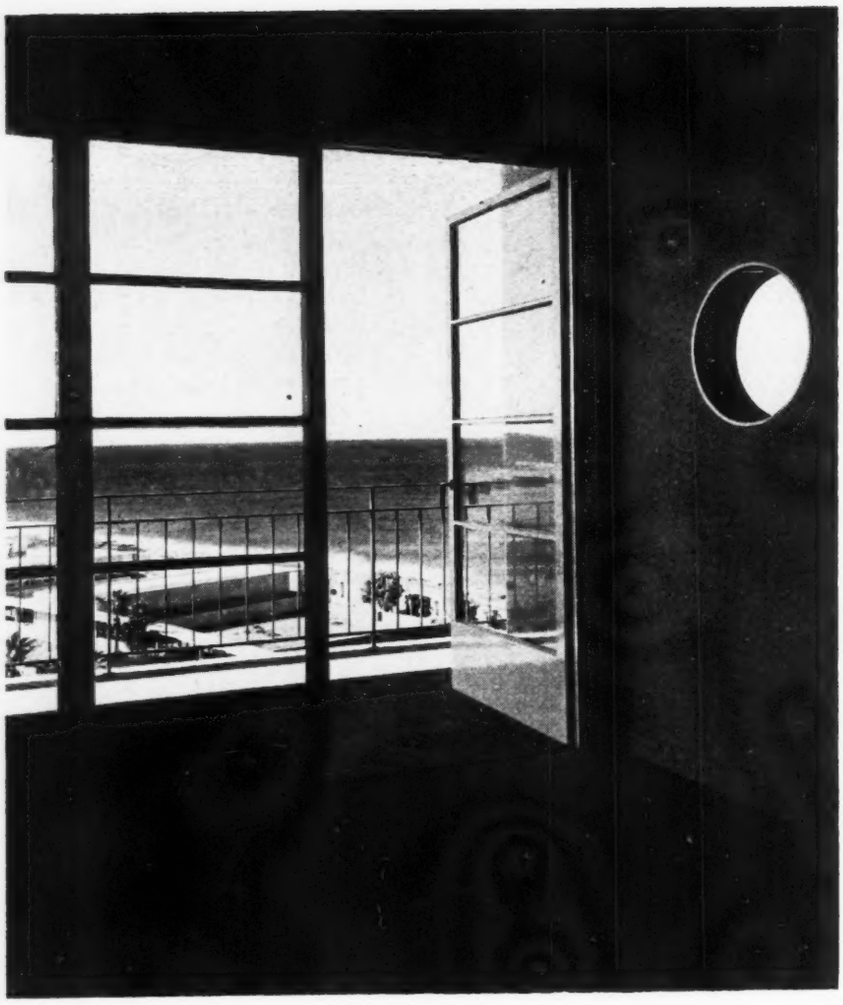
We have utter freedom to produce buildings of any shape that fits the program and the site. And today there are architects who will come up with a result as well studied, as beautiful, as inviting, as appropriate as any that is rigidly similar on both sides of its major and minor axes.

Perhaps the first noticeable change in hospital plan arrangement has been completely correct orientation. The studies of space used have indicated which rooms should be on the north and have no direct sun; which might be placed on the east and west and profit from partial sunlight. In addition, there have been studies tending to show the sterilizing and bacteria destroying qualities of sunlight, which reinforce our desire to place patients' rooms on the south side of the building.

On the part of the designing professions there have been investigations into the ***control*** of daylight, so that the quantity and quality of direct light can be planned, so that brightness can be engineered and glare can be eliminated. The coordination of natural and artificial light and the study of the ***type*** of light needed for different purposes have resulted in findings that progressive designers have been quick to use.

Incidentally, the important studies have been made by school people and translated by hospital designers; there is a great opportunity for those interested in the design of hospitals to do some particular research in more detail on lighting and brightness needs in the various parts of a hospital building.

Orientation is something that every architect has always thought he solved properly, but it is interesting to note that when the plans of the hospital at Sylacauga, Ala., were published in August of last year, it was pointed out that here is the first general hospital actually to be built



Photograph by Alfred Bernhein.

Fever pavilions of General Hospital, seen from the main building.

in the United States with all patients' rooms organized along the southern walls. Inconceivable as it may seem, there had always previously been compromises forced by formalism in design or inadequate understanding. Here, then, is an important trend.

The second most striking tendency, in my opinion, is proper attention to circulation. In this case as well it is probable that no architect would ever admit to neglect of circulation studies. Yet all of us know outpatient departments with the entrance and the exit centrally located and treatment and examination spaces haphazardly placed. Not until careful studies had been made of patient travel from one room to another was it possible to plan rationally the sort of outpatient space we now see as an increasing "trend" —the space which leads the patient in at one end, through waiting, registration, history taking, examination, treatment and out past the pharmacy.

Circulation also involves the proper relationship of departments within the hospital. Many administrators know the lost efficiency, many doctors know the chances for infection and cross infection, many patients know the inconvenience, when travel from a nursing unit to a therapy room or an operating suite or recreation spaces leads past or even through other departments.

The parts of a hospital are like the pieces in a jig-saw puzzle, and most designers today, in their preliminary planning, make studies which do nothing but arrange departments and the circulation to and fro. Details can come later, but even in details the trend today is toward the study of circulation. For instance, within a utility room there are many ways the equipment can be arranged, some leading to confusion, some to insanitary work, some to efficient cleanliness and separation of functions.

The third noticeable trend may seem to be a paradox—planning for complete functional use, while allowing for flexibility and future change. There are many reasons why this is an increasing practice. As one example, we need many more beds for the tuberculous today; we must plan them and build them for that specialized purpose. When the far-sighted actions now being implemented begin to check and then reduce the incidence of this disease, we will want to convert some of our tuberculosis hospitals to other purposes. Will this be possible?

To choose a smaller instance, there is much advanced and continuing study on the subjects of physical therapy and psychotherapy. These departments must be planned for maximum efficient use according to our understanding while we are planning. Does this mean that changes to adapt themselves to later findings will be impossible or exorbitantly expensive?

A rational movement within the building industry, plus technological improvements, makes this sort of flexible plan use possible—without vitiating careful scheming for specific use.

Based on 4 Foot Module

If you will study the prototype plans issued by the U.S.P.H.S., or the plans of any other progressive architect, you will see that they are based on a 4 foot module. Instead of making a room 11 feet 10¾ inches wide, the designers have made it 12 feet wide. Instead of placing windows to suit a formal esthetic or a contorted plan, they have placed them on 4 foot centers. Going up and down from this 4 foot module, the trend continues.

Even such small items as brick, metal and wood windows, tile and glass blocks are now being manufactured to fit this sort of modular planning. Brick used to be 8 inches long, laid with a ½ inch joint. Now it can be obtained 7⅝ inches long, to be laid with a ⅜ inch joint, so that center to center of joint is 8 inches. Six bricks make up precisely Marshall Shaffer's 4 foot module. Then the structures can be planned so that columns are spaced, let us say, exactly 16 feet on centers—four of the 4 foot modules to a structural bay. Inevitably, the trend toward this sort of planning will result in

flexibility. Rooms can be replaced, just as stock laboratory furniture is now replaced, when original purposes no longer exist.

To make more possible this freedom to change, we shall have available in a short time movable and removable partition materials with finishes as attractive and as sanitary as any surface that can be applied to a masonry wall. We have speculated all during the war about the wonderful new materials for the postwar world. Now many items that held promise of more rational, more flexible construction are in actual production. While the housing emergency will absorb many of them for some time, the very stimulus from the housing expediter's office will make certain ones more quickly available.

The list of trends could be longer and illustrations could be more numerous. The all-important factor of overall planning and comprehensive study, in turn, affects favorably the design of particular institutions, and it would be interesting to explore this. The trends we speak of are symptoms of a more basic rationalization. We recognize social needs and then we see hospital staffs, administrators and designers studying their problem more carefully. These are design considerations, yes, but they came to fruition not as technical exercises but as a result of greater interest in the health of the world.

Report on Cook County Hospitals

AN ESTIMATED shortage of 4500 general and 11,500 special hospital beds in the Chicago area was reported January 8 when the U. S. Public Health Service published the results of its survey of hospital and health facilities in Cook County. The survey also disclosed a serious shortage of hospital personnel, lack of facilities for Negro patients, fire hazards and faults in food handling technic.

"Doing Tremendous Job"

Nevertheless, the report stated, in view of present day problems the hospitals in Cook County "are doing a trementlous job and for the most part are doing it surprisingly well."

The survey, which covered a period of ten months, was made at the request of local government and hospital authorities. It was conducted by a staff of 25 investigators headed by Dr. K. E. Miller of the U. S. Public Health Service. Dr. Edward T. Thompson, formerly administrator of Mount Sinai Hospital, Milwaukee, and a colonel in the medical corps during the war, directed the study of hospitals, clinics and medical care.

"Newspaper reports of the survey have emphasized hospital deficiencies and may unduly alarm the public," Dr. Roger W. DeBusk, president of the Chicago Hospital Council, told The MODERN HOSPITAL. "The bed shortage, the shortage of trained personnel and current equipment and construction problems have affected hospitals all over the country, yet for the most part standards of patient care have not suffered in any essential factors.

"As a matter of fact, because of our good fortune in having four great medical schools here, the quality of hospital care offered in the Chicago area is considerably above the national average. Yet the report has publicly underlined our shortcomings, many of which are unavoidable today, with only token credit to hospitals for their performance in the public interest under difficult circumstances."

In addition, E. E. Salisbury, executive secretary of the council, pointed out that, since the survey covered a period of several months, many of the conditions it reported had already been corrected at the time of publication. "The published report may give the impression that hospitals are fire traps; it may needlessly frighten thousands of patients and their families," Salisbury said. "Actually, while a few institutions may ignore fire safety warnings, most hospitals comply as rapidly as possible with recommendations made by inspectors. In a city like Chicago fire regulations change rapidly, and a certain lag between actual and recommended conditions may sometimes exist. This is not necessarily a cause for alarm."

Of the 4500 general hospital beds needed for the area, according to the survey, approximately 900 should be in governmental hospitals. Other facilities needed include: 3500 beds for mental patients, 2000 for tuberculosis and 6000 for chronic diseases. The survey indicated that most hospitals were turning away patients for want of space, but that approximately 600 of the county's 17,000 general hospital beds were closed because of the personnel shortage.

The gravest inadequacy revealed in the report was in facilities for Negro patients. Only 315 beds are available for Negroes, it was stated, although the estimated need was for 2700 beds. This problem, the report declared, "had not been faced frankly by the community." The survey also scored food handling methods in hospitals: "It is evident that those responsible for food service need to be taught the fundamental principles of good sanitation and hygienic practice." Investigators acknowledged, however, that their food service sampling might not represent an accurate cross section of conditions in all hospitals.

Planning Committee Needed

Recommendations by the survey staff included discontinuing hospitals of less than 100 beds, closer cooperation between government and voluntary institutions, elimination of racial barriers, acceptance of tuberculous and mental patients by general hospitals and the organization of an eight man administrative commission to operate all tax supported hospital facilities. It was also recommended that a widely representative hospital planning committee be formed to coordinate future public and voluntary hospital expansion.

Microfilm Casts Off the Shackles

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MICROFILMING medical case records at East Liverpool City Hospital, East Liverpool, Ohio, was the solution to an overcrowded condition in the clinical record department that resulted from general hospital growth and a desire to keep faith with patients through preservation of their records.

During the past few years the daily patient census increased so rapidly that bed space was at a premium and important units, such as the clinical record department, although they grew in direct proportion to the hospital, became secondary in space importance. The natural outcome of such action was that valuable medical case records were stored in inaccessible places and instead of serving their important function became dead matter. Only the mice, dampness and other fingers of the hand of destruction were interested in their valuable content.

Advisable to Keep Records

While no definite ruling regarding the preservation of hospital records has been adopted by national hospital associations, it is advisable to keep them as long as there is available filing or storage space. From the legal point of view, it is advisable to keep them for the period covered by the statute of limitations; from the patient's point of view, it is advisable to keep them during his life; scientifically, for the sake of comparative group studies, the period may extend indefinitely. Thus, hospitals have the obligation of providing accessible filing or storage space so that medical case records may continue to be actively used.

Every hospital in good standing is cognizant of that obligation and has a program for the improvement of medical case records. The program is advanced by analysis of records, assimilation of content and the subsequent formation of principles to guide future professional care of patients.

East Liverpool City Hospital realized that space provision, either by enlarging the department or by decreasing the content, was necessary for the medical record department. The former course being impracticable, attention was directed toward the latter which presented the dual possibility of destroying or microfilming old records.

After exhaustive study of competitive exhibits at hospital meetings, magazine articles, letters from hospital administrators who had blazed the trail on modern methods of record preservation, legal opinions, cost analyses and demonstrations by various microfilming services, a contract was finally signed. All fear and apprehension that microfilming might not be the solution to our problem faded with the signing of the contract. The die was cast and attention was directed toward the period of preparation.

While awaiting the clearance of governmental regulations which prevailed at the time, important administrative decisions regarding procedure were made and medical case records were placed in order, to prevent delay after the beginning of rental charge for the machine. Utilization of this period was a contributing factor to keeping the entire cost of microfilming below the estimated cost. During this time, a survey was made of all charts which had been filed alphabetically so that all charts pertaining to one person would be filmed in sequence; another survey was made of all charts filed numerically so that their filming would be in numerical order and none would be lost through omission. Decisions were made that (1) all charts from 1919 to 1941 would be filmed; (2) all charts from 1941 to 1946 would be kept in original form, and (3) the entire chart would be filmed.

All component parts of the charts were assembled in definite order; blank pages were deleted; fasteners were removed; a brochure of pertinent literature was made and studied, and a competent person was employed to learn the microfilming process. Through the decision to film the entire chart in all cases, much time was saved as the filmed record is acceptable in all litigation if the original record was intact when the filming was done.

Learned Details of Microfilming

By the time the equipment arrived, all charts and their component documents were in order and the operator was familiar with the medical case records and the routine of the medical record department. The details of microfilming were taught by the manufacturer's representative and filming began under his capable direction.

The operation of the equipment was simple because the machine works almost automatically. The photographing was done on 16 mm. film and documents varying in size and thickness were fed into it at an average of 1500 an hour. The gauge was set to accommodate documents of varying thickness inasmuch as the selective feeder would not operate if a document had a thickness beyond the set of the gauge. The feeder, synchronized with the movement of film past the camera lens, took the documents of varying size but the film moved only the required amount so as not to be wasted. The red light in front of the operator signified

Details of Microfilming East Liverpool City Hospital Medical Case Records (1919-1941)

Records Photographed (number of charts)	41,560
Exposures (number of documents)	720,362
Length of Each Film	100 feet
Average Number of Exposures per Roll	3,463
Average Number of Exposures per Record (documents per chart)	17.3
Average Number of Charts per 100 Feet Film	200

Net Cost of Material Exclusive of Rental and Wages

Cost of Developed Film (200 charts)	$ 2.75
Federal Tax and Film Postage per 100 Foot Roll	0.40
Cost per Chart (17.3 documents per chart)	0.01575
Cost of Developed Film for 41,560 Charts (720,362 documents)	654.57

Total Cost Including Rental and Wages

Rental of Equipment for 4 Months	$ 200.00
Cost of Film Including Developing	654.57
Postage on Film	23.55
Express Charges on Equipment From Factory	14.87
Freight Charges on Equipment to Factory	7.50
Salary of Operator	494.50
Total Net Cost per Chart	0.0335
Total Net Cost per Document	0.0019
Total Cost	$1,395.0254

Space Required for 41,560 Records (140 closed files)	310 cu. ft
Space Required for 208 Rolls Film (41,560 records)	3.12 cu. ft

proper working of the machine; even though the motor was running, the film was not being used unless the light was on.

If errors such as over-riding of pages occurred, the film was cut and correct film was inserted by splicing, just as a movie film is cut and spliced until the desired result is obtained for screen presentation. The pages, as they were photographed, fell in their original order into a holder. They were returned to the files and kept until the film was returned from the developing center and was inspected on the projector to assure the operator that the recording had been done correctly.

No Reindexing Necessary

After it was determined that the film was satisfactory, the original records were destroyed under the direction of a responsible person. The box in which the film was stored was labeled with pertinent information and filed in the proper place. No reindexing was necessary as the card index of the original system was used for files of filmed records.

The projector sits upon a table in a darkened corner of the medical record department where the physician or other interested person can read the film in comfort inasmuch as the operation for reading is simple. The film is run through the projector to the desired document and read from the enlargement on the ground glass screen. If a written record is desired, the clerk can make a certified copy, or an 8½ by 11 inch photograph can be made of the document by inserting sensitized paper in the projector and developing the impression in a special darkroom or in the x-ray department. Either method of reproducing is satisfactory for reviewing the medical case record in the department or for taking it to court in case of litigation.

From our study we learned that the legality of filmed medical case records has been definitely established and that the photographed record is fully accepted. There is no question of intent to defraud on a certain record when all records of a given group or period have been filmed. The record is projected in its original form and handwriting and signature are shown on the ground glass screen as they appear on the original record. In addition to many published statements of legal opinions, a specific ruling from the hospital's attorney verified the legality of the photographic or photostatic process in recording legal papers.

If a subpoena is received for a medical case report, one can meet the hospital's obligation by taking the film to court with or without the projector (it is not the hospital's responsibility to furnish the means of reading the film but if the court's good will is a matter of concern, the projector may be easily transported); by taking a certified written copy, or by taking a photographic or photostatic copy.

There is no definite time limit set by law for the preservation of medical case records but it is advisable to keep them in their original form during the period of the statute of limitations. This length of time varies in different states. In the case of children, the statute of limitations may not begin to run until the child has reached the age of 21; hence the medical case record for a newborn infant should be kept in the original form for twenty-one years plus the time required for the statute of limitations to expire. The alternative to this method is to film the entire record.

In order to save the time that separation of medical case records into age or other groups would consume, we decided to film the record without change or deletion. This meant the filming of voluminous bedside notes which are considered only secondary evidence in cases of litigation but which sometimes contain certain information that is not to be found on other parts of the record.

Everybody Approves the Result

The innovation of microfilmed storage for the medical case records of East Liverpool City Hospital has met with unanimous approval on the part of the board of trustees, the medical staff, the hospital personnel, representatives of the legal profession, insurance companies, social agencies and all persons interested in obtaining accurate information in a minimum of time. The ease with which this is accomplished is a direct result of reducing filing space requirements in the proportion of 100 to 1 and placing all medical case records in a small cabinet at the finger tips of the medical record librarian. The information is ready for use at all times and offers the utmost in satisfaction when dealing with progressive hospitals and agencies that have installed microfilmed records.

In addition to convenience, space saving and accessibility, there are advantages, such as protection against fraudulent modification of medical case records, lessened fire hazards, stimulation for improved record keeping, elimination of misfiling, saving of time, elimination of dirt and dust hazards and permanency.

The analysis on page 55 of the microfilming operation in the East Liverpool City Hospital gives interesting details.

The cost of microfilming twenty-one years' accumulation of medical case records (more than half a million documents) was conservative in comparison with estimated building costs for adequate filing space for the original paper records. In addition to the cost factor, there is no tangible method of evaluating the benefits of accessibility of medical case records and the satisfaction of personnel stimulation.

East Liverpool City Hospital is another institution in which the medical record department has cast off the shackles of antiquated methods and has taken on an atmosphere of aliveness because a modern system of microfilming medical case records has been installed.

Army experience proves that

Psychiatric Patients Belong in a General Hospital

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IN CONTRAST to usual practice in civilian hospitals, the army made provision for the treatment of psychiatric patients in practically all its hospitals.

There could be no refusal to recognize the fact that psychiatric disorders were as common as was acute appendicitis or pneumonia. In the army it was known that the patients would be there and they would have to be treated.

Doctors worked in close cooperation with one another and it was not possible to camouflage psychiatric disorders under organic diagnoses as is done so commonly in the privacy of office practice.

It is true that the army hospitalized many more patients with the milder psychiatric disorders than is done in civilian life. This was necessary because if a man could not do duty he had to be removed from his organization and the hospital was the only place he could go. Because of this, army experience cannot be considered typical—but there were many things that were learned.

Psychoneurotic Disorders. In the beginning, patients with psychoneurotic disorders, who were admitted to hospitals, were generally disposed of as rapidly as possible (to duty or discharge) in accordance with army policy.

Despite the absence of official encouragement some neuropsychiatrists attempted to give definite treatment to as many patients as they could but they were hampered by the large number of patients they were called upon to see.

However, as time went on official directives stressed the importance of treating patients with psychoneurotic disorders and excellent and effective treatment programs were established in many station hospitals and in the general hospitals which were specifically designated as psychiatric centers. Utilization of the team of psychiatrist, psychologist and social worker and of the varied adjunct activities of the reconditioning program of the hospital made it possible to give large numbers of patients a well rounded treatment program.

The later development of special convalescent hospitals made it possible to treat psychoneurotics away from formal hospital atmospheres. Their emotional difficulties could be approached more directly without the temptation to resort to more unnecessary searching for physical bases for their disorders.

The successful treatment of patients with psychoneurotic disorders in the convalescent hospital proved to be one of the big advances in psychiatric treatment which were accomplished during the war.

Psychotic Disorders. More dramatic than the experience with the treatment of psychoneurotics was that with the psychotics. Quite unlike the situation in civilian life, provision was made in almost all hospitals for treatment of patients with severe psychiatric illnesses. Psychotics were not put in the guardhouse or brought before a court-martial prior to their admission to a hospital for treatment.

It was not economical or feasible to maintain definitive closed ward psychiatric treatment units in the smaller

hospitals. It would have been wasteful of the psychiatrists who were too few from the start. Furthermore, a total activities treatment program could not be built around a small handful of patients. In all of the larger hospitals, however, not only was it possible to provide facilities for these psychiatric patients but it was thoroughly practical to provide complete treatment.

Closed psychiatric wards were included in hospitals at all of the large army posts in this country. They provided a service which was unique when compared with the average community hospital.

Psychiatry was once again brought close to the rest of medicine, and the feasibility of maintaining a psychiatric section in a general hospital was proved beyond any doubt.

As the war progressed, and as it became necessary to make provisions for the large number of psychiatric patients who were being evacuated from overseas theaters, 26 general hospitals were designated "psychiatric centers." In each of these hospitals a neuropsychiatric service of from 100 to 1000 beds was established. The size of the closed ward section varied from 75 to more than 400 beds. Intensive treatment programs were provided in all of them. It was possible to include the various types of physical therapy, occupational therapy and recreational activities.

Created No Disturbance

The neuropsychiatric service was an integral part of the hospital and in no instance was its presence a disturbing influence on the rest of the hospital. The staff of neuropsychiatrists provided a ready consultation service. It contributed to a better understanding on the part of other members of the medical staff of the rôle of emotional disorders in medical and surgical disorders. Better treatment of patients with functional disorders of the gastrointestinal tract, cardiovascular, genito-urinary and musculo-skeletal systems was made possible by virtue of this better understanding. Psychosomatic medicine took on added significance to the average doctor.

Psychiatrists were able to make much greater contributions to the work up of patients than had been possible before. Their extremely important work with psychotics was seen to be only one small phase of their function in a complete medical program.

Application to Civilian Psychiatry. In most civilian hospitals throughout the country little or no provision is made for the treatment of psychiatric patients requiring close supervision. The reasons generally given are:

1. Prolonged hospitalization is generally required, and any facilities which were provided would soon be fully occupied and unavailable to new patients.
2. The need for special services, such as occupational therapy shops, reception rooms and hydrotherapy.
3. The disturbance created by the psychiatric patients.
4. Legal complications.
5. Special personnel requirements.

In reality, none of these arguments is valid and one is left with the conclusion that the old fears and prejudices relative to mental illness and lack of information concerning them and their treatment are responsible. The psychotic patient remains a mystery to a great part of our medical profession. There has not been a sufficient number of psychiatrists on general hospital staffs to make the psychiatric needs of the community known to the medical boards and boards of directors of the hospitals. The mentally ill patient is forgotten when the planning is done.

With modern treatment methods chronic psychoses can be prevented by giving prompt attention to acute psychotic reactions. In the army, only about 25 per cent of patients admitted to hospitals for closed ward treatment required further hospital treatment upon discharge from the army; approximately 75 per cent, after an average of sixty days of hospitalization, were recovered or well enough to be discharged to their own custodies or to the custody of relatives. Such results would not have been obtained if treatment had been delayed by time consuming commitment proceedings, transfer to mental hospitals and long "periods of observation" prior to the institution of treatment.

A majority of patients in private practice who require hospitalization for mental disorders are willing to enter a hospital voluntarily, especially when they can continue to be cared for by their own doctors in hospitals in their own communities. Many of these patients require only brief hospitalization, time enough to get over a state of panic, depression or confusion. These cases are just as much emergencies as are many cases of right lower quadrant pain that are rushed to hospitals.

The patient with hemoptysis is not hastened off to a remote sanitarium when symptoms first appear. Rather, he is admitted to a general hospital for emergency treatment and work up. When these are completed, when long hospitalization is indicated and when the patient's condition permits, the patient may be transferred elsewhere for continued treatment.

Feasible for Acute Cases

There is no reason why psychiatric patients cannot be cared for in a similar fashion. A closed ward psychiatric unit in every general hospital is perfectly feasible for acute cases.* The unit should be approximately 5 per cent of the total beds, so that a 500 bed hospital would have a closed psychiatric section of 25 beds. Half of these beds could be of the dormitory type and half, private rooms. A dining room, recreation room and occupational therapy facilities can be provided in a fairly compact space. A tub and pack room, offices and treatment rooms complete the unit.

Voluntary patients could be given intensive treatment for from thirty to sixty days and transferred to specialized psychiatric hospitals if additional prolonged treatment is indicated.

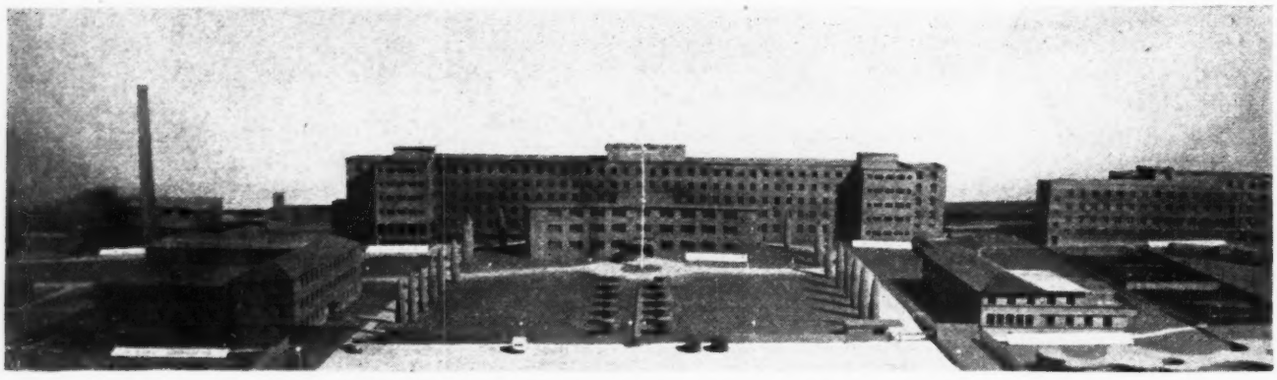
Elaborate operating rooms, physical therapy and x-ray departments are included in most hospital plans. The special facilities required for a psychiatric unit hardly approximate those for these other departments.

Legal complications can be completely avoided by accepting only voluntary patients and such others as are permitted by local laws.

It is to be hoped that the army's experience will not be ignored in the future planning of hospitals. The Veterans Administration is planning to include psychiatric units in all new general hospitals and in as many of the existing general hospitals as is feasible. A small number of progressive civilian hospitals have facilities for psychiatric patients but in most communities the needs of the psychiatric patient are still unrecognized or ignored.

*Bennett, A. E.: Psychiatry Is Good Business in the General Hospital, Mod. Hosp. 67:43 (July) 1946.

From War to Peace: A Hospital in Transition



ARCHITECT'S MODEL, HEIDELBERG MILITARY HOSPITAL, MELBOURNE, AUSTRALIA.

P. H. COLSTON
Secretary
Leighton Irwin and Company
Architects-Engineers
Sydney, Australia

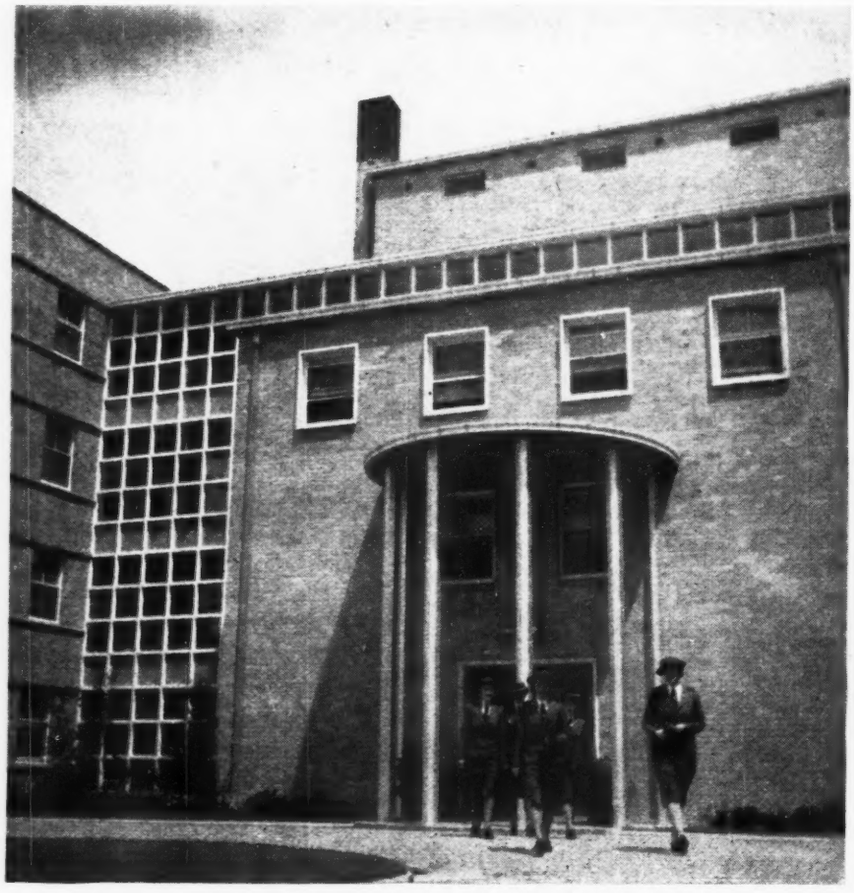
THE provision of a large hospital that is adequately flexible and expandable is even for a stable community and at the best of times a major undertaking. To provide a military hospital scaled to become Australia's principal repatriation institution and, in the meantime, to cater to a mounting influx of casualties from a front desperately stemming invasion was an even more exacting problem.

About to be taken over according to plan by the Repatriation Commission, the Heidelberg Military Hospital in Melbourne, Australia, has attracted wide attention as a notable solution.

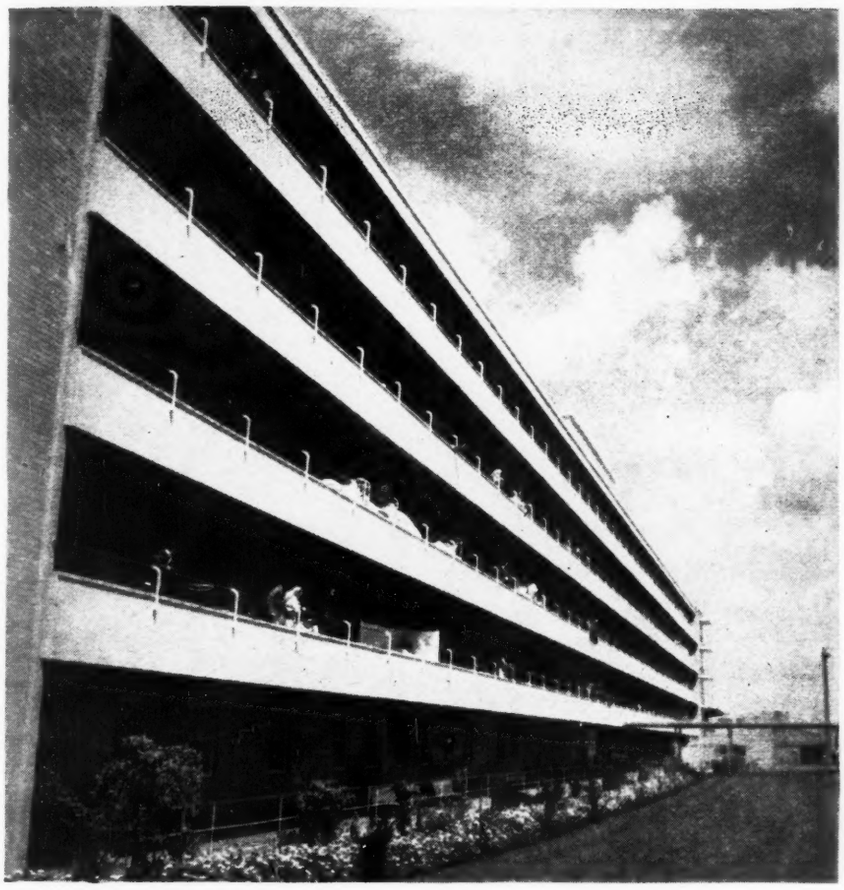
One can hardly avoid reference to the moral of careful and comprehensive basic planning. The Commonwealth government tackled the problem by dividing it into two parts, the permanent and the temporary. The 65 acre site was likewise divided, by a road, and an experienced firm of hospital architects was engaged to develop the permanent section on one side of the road and coordinate with it the temporary section which the Department of the Interior undertook on the other side.

The permanent section was the Repatriation Hospital of the future and was designed to be self contained. Its ward accommodation was to serve the combined hospital as an "acute block" with the less acute cases distributed among the pavilions of the temporary section, and it was to provide the living quarters and the greater part of the services.

The requirements and modes of working of the wartime military hospital and those of the repatriation hospital naturally differed considerably. A large factor in the concurrent satisfaction of both was the attention paid to lines of movement, both within and without the building. The admittance of patients in war time, following the arrival of hospital train or ship, required a central clearing point from which



Entrance of nurses' home, showing glass blocks in prefabricated frames.



The balconies on which convalescent patients enjoy air and sunlight are long and wide and separated from wards by glass paneled walls.

cases could be directed to the appropriate building with the utmost dispatch.

The general disposition of the hospital building is as follows:

On one half of the site are the pavilions, set out on a rectangular grid.

On the other side of the road, flanking it for 600 feet, is the multistoried acute block.

On the south side of the acute block, and centrally linked to it, is the operating wing.

A train of ambulances turns into the roadway and pulls up at the center of the acute block, abreast its entrance hall and beneath a covered way that spans the roadway and proceeds to the pavilions, linked to each. From this point a patient is rapidly transferred to a particular pavilion, to the acute block or straight through to the operating theaters.

The more normal routine of the peacetime repatriation hospital is provided for on the other side of the acute block. A one way driveway approaches from the south, curves around the operating block and passes right through the link between it and the acute block, thus giving direct and sheltered access to administrative, casualty, operating and ward areas. It also provides the formal entrance to the hospital, the loop of the driveway forming a great quadrangle flanked on opposite sides by the quarters of the army medical corps and of the medical officers.

The site slopes across this quadrangle along the length of the acute block. The nurses' quarters are located on the highest ground whence they command views of hills, city and bay. On the lowest ground are the laundry and boiler house.

The hospital laundry system works on the exchange principle. Trolleys collect soiled linen from each section, deliver it to the laundry and receive in return an equivalent amount of clean linen. Thus, at the laundry building itself receipt and dispatch sections adjoin each other. Clearly, the quickest method of disposal of soiled linen is by chute, whereas clean linen, ironed and folded, is well suited to movement by conveyor belt.

In other words, the most efficient system of working within the laundry is a gravity system from the second floor level with conveyor return. This is the significance of the location of the laundry at the lowest

In the main kitchen 5000 meals are prepared daily for patients and staff.

site level. It enabled a branch to be taken from the roadway at a higher level near the acute block and to be elevated as it proceeded westward over falling ground, to meet the laundry and boiler house at second floor level.

The boiler house employs a gravity system equally effectively. Coal trucks end-tip their loads into bunkers from which chutes lead to the chain grate stokers that feed the boilers. Beneath the boilers are rail trucks into which the ashes spill for final disposal. Finally, the elevated road serves as a roof to extensive garage space.

The ground slope has been further harnessed to facilitate feed distribution within the giant acute block. Two factors made this an unusual problem. First, because Heidelberg was a military establishment, each floor of the main building was organized as an individual army unit with its own messes. To these, all of the hot food had to be transferred in bulk.

Second, the building is large not only vertically but horizontally. Most multistoried hospital buildings consist of wings extending from a central shaft which serves the hospital much as the trunk serves a tree. Below are the central supply rooms. Elevators, light, power, gas, steam and sterile water come up the shaft and branch to each floor.

Heidelberg's acute block is like three trees with common roots. There are three banks of elevators, one at each end and one in the center. This lends itself to the organic reticulation of pipe lines but creates quite a location problem for the kitchen.

Obviously, it could not occupy that vital area, the center of the ground floor. Nor could it be located satisfactorily in the basement, the maximum of natural light and ventilation being desirable. By utilizing the sloping ground level, an ideal situation was found—at the west end of the building at ground level. This gave it all the natural light and air it required; isolated trades' vehicle traffic; gave it direct access to the western elevators, and placed it at basement level relative to the rest of the building, thus enabling uninterrupted passage to the other elevators by means of a tunnel beneath the building.

This tunnel also carries all the horizontal pipe mains to the three vertical shafts and, in a branch, to beneath the operating or south wing, which greatly facilitates maintenance.

The operating section itself forms the second floor of the south wing, the first floor being, in effect, an outpatients' department and the third floor, a pathology section. All have the benefit of even south lighting. The upper floors are air conditioned and in the operating section the entire corridor serving the theaters and auxiliary services forms a sterile air lock.

Each ward floor of the acute block provides beds for 120, made up of four nursing units of 30 beds each. The utility and staff rooms are kept on the south side of the main corridor and the wards occupy the north side, sheltered from summer sun by long, wide cantilevered balconies which run the full length of the building.

The northern "wall" of the hospital is, in effect, all window. Within the framework of the structural columns, it consists entirely of a grid of precast concrete frames forming panels 2 feet square. In these are set glass louvered ventilators where required and, from each ward, double doors to the balcony. In such quantity these frames are economical and quite pleasing in appearance from both inside and out. They have been used again effectively in the nurses' home.

Prefabrication is at present being carried even farther by the architects in new quarters for the occupational therapy section, hitherto located perforce in the pavilion section. This department, which links the work of the military hospital of the past and that of the repatriation hospital of the present, must be even more flexible than other hospital units. The types of "occupations" it provides will vary with time and circumstances, and their accommodation, built of standard panel units, will be capable of closely following all changes and fluctuations.

The outstanding feature of Heidelberg Hospital is undoubtedly the careful planning of the whole which is enabling the smooth transition of a hospital of war to one of peace.

Looking for a Stable Working Force?

It All Goes Back to GOOD LEADERSHIP

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WORKING conditions can play a major part in enlisting minds and hearts and hands in the service of the sick. When one finds 1300 people doing volunteer work in a single hospital, it is no longer possible to underestimate those latent ideals which can become the mainsprings of new effort and which money alone does not reach.

One of the natural tendencies of management in all occupations is to overlook the power of the simple human ideals and to assume that money is the only incentive to which people respond. Desirable working conditions may be defined as that aspect of environment which, in their opinion, maintains or improves environment in the employes' homes or in other places of employment available to them.

I recall 700 men in overalls, half of them upstairs and half downstairs in the same building. They were doing approximately the same type of work, using the same materials and earning the same pay. They were under the same supervision. For a long time the men downstairs worked reluctantly and quit their jobs at twice the rate of loss prevailing among the men who worked upstairs.

These men leaving could not tell their reason for leaving, at least no *common* reason could be found from them. They were not hostile to the company. If a vacancy upstairs was offered them, they would accept it. After months of this, and in the absence of a statistical answer, a half day was devoted to observation downstairs. It brought the answer. It was a very human answer. The men were not *stepping* along actively about their tasks. They were *shuffling* along at a leisurely gait.

The ceiling was low; the room was dark; the lights were not turned on in the daytime; even when they were on, the bulbs were black with dirt; the walls were dingy. The place was gloomy. Upstairs the windows were high. Skylights kept all parts of the broad room light and cheerful. The men downstairs unconsciously felt themselves in a dungeon. To them, the upstairs men in overalls had a white collar job.

Painting the downstairs walls and equipment white, washing the electric bulbs and turning the lights on all day made the downstairs work, too, a white collar job. The losses of help came down. Production rose substantially. Even men in overalls have ideals as to working conditions.

Working condition problems in a hospital would take a different form, of course. For instance, women perform a large part of hospital work. How many hospitals have restrooms for them which can be compared creditably with those in factories?

No doubt most hospitals take care of their employes when they are ill. But how many have made it a policy to do so and have told the employes how to take advantage of it?

Every union contract requires an organized procedure for presenting grievances or problems, aimed to assure impartiality, to give greater job security and to ensure the proper operation of the institution's or company's written personnel policy. The employes are informed how to take advantage of it and are protected when they do so. Supervisors have quite as many problems and grievances and they deserve as much protection as do their subordinates.

It is inevitable where people are gathered together that frictions and misunderstandings and rivalries occur and that many see not the whole picture but only their small sector. How many hospitals have set up a court of justice to handle these prob-

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lems, to be a vent and a safety valve for excess steam? Is it available for both supervisors and subordinates? A management doesn't need to wait for a union to compel a problem or grievance procedure. Massachusetts General Hospital has set a good example of voluntary action.

Not all working conditions have their origin in management. A single worker's influence may curtail the output of a group of workers. A few workers of low moral tone in a group can cause a better type of worker to leave or avoid the department. Courage to act is a favor to all parties in such cases.

Let's Have Good Housekeeping

The working conditions experienced at the place of employment exercise a surprising influence upon the working conditions at home. Housekeeping in a factory in which gold is handled must be immaculate. Even the dust is money there. The interior of homes of employes accustomed to that kind of factory housekeeping will be found equally immaculate, as a class, regardless of earnings. This will not be found to be typical of the homes of workers in dusty industries, for instance. Toilets, too, are especially easy to get out of hand whenever considerable numbers are employed. But persistence pays.

Good housekeeping on the job attracts people from the better homes, lifts the home standards of all and influences the community favorably. This is one way to help employes and their families to grow. And they do want to grow. On the other hand, the average home has raised its standards during the war. Employers may have to step even to keep up with homes.

Working conditions, however, are not entirely physical. There are also emotional and social working conditions. A majority of high school class pupils will work for one company because they were friends in school and they want to work together. Can hospitals do something in a social way to foster friendship with and among their employes? To thousands of people their job is home. They like its atmosphere.

Can't the job be given a social attractiveness so that employes not only make money but make friends in their hospital? It's easy. A little space and a little leadership and they will do the rest themselves. People will always be thinking. No employer can suppress or retard that. But an employer can do much to turn group thinking into cheerful and jolly, rather than gloomy, thinking and the workers will love it.

Henry Ford says that the productivity in his plant has gone down 34 per cent per man. An unfortunate nationwide emotional atmosphere is the cause. It is not lack of money. They were the best paid workers in America as a group. The fact that productivity was once 34 per cent higher is proof that it can return there. His problem and that of the hospital are how to counteract this nationwide emotional atmosphere. Ways can be found.

We haven't learned the art of managing human beings as well as we have learned the art of healing them.

It is time to apply some of the science devoted to healing to inspiring teamwork and fondness for their hospital associates among those who do the healing, both professional and auxiliary. Since the war, considerateness of the other fellow hasn't proved itself exactly an American trait. But it can be made a hospital habit.

Employes are searching for leadership in which they can have confidence. They want attention not sympathy; friendship not paternalism; discipline not leniency; criticism and compliment, but neither alone; security against favoritism or unfairness; considerateness of their family problems as well as their job problems; sincerity without bluff or threat; patience rather than petulance. These are emotional, not physical, working conditions. Can anyone provide them better than can the hospital management?

How well a hospital induces its people to do their best for those who suffer depends upon the leadership which it offers in respect to working conditions. It does not depend upon the method of intercommunication but upon the attitude communicated.

We should all like to be knights in shining armor at the head of columns of crusaders. As individual officers, we feel that no one is more sympathetic with our followers than we are. Probably the first step to take toward wise leadership is to realize that this is not the best way. No one person can lead. It is the captains and corporals who must provide the needed leadership. Direct dealing by managers with the subordinates weakens the supervisors who must do the leading day in and day out, as well as on the show occasion.

The supervisors must be given a personnel policy to guide them, then should receive authority commensurate with the responsibility to put the policy into practice in their own departments. It is the part of wisdom to strengthen their hand when they follow this personnel policy. The supervisors need to be consulted, trusted until removed for cause, supported, trained, kept informed, given tools and in every way made to feel themselves a trusted part of management rather than closer to their help. Only the supervisors can properly get close and remain close to subordinates and they can't avoid it. They know their subordinates better than management can.

Sensitive to Workers' Interests

Supervisors should be sensitized to the workers' interests, if they are not already sensitive, and should transmit those interests frankly to the management; conversely, they should transmit to the workers the hospital's considered personnel policy, both in word and in deed. Management needs to meet with its captains and corporals, not merely individually, but together, regularly and often and should keep them together with clear objectives.

Wise management will keep each member of the supervisory group reasonably satisfied with his own lot, his own pay and his own job security. In any general adjustments in compensation the supervisors will be taken care of first. Rivalries for the favor of management which tend to pull other supervisors down will not be countenanced by management.

The emotions of "supervisors," using that term broadly, are contagious.

The supervisory group should be vaccinated not negatively *against* discontent, rather, positively they should be inoculated *for* giving one's best effort in a spirit of contentment, friendliness and liking of one's job. Contentment, too, is contagious. Keep in mind that supervisors can join a union if they prefer, deplorable as that would be.

When management has a clearly defined and sound personnel policy which respects employes as self respecting individuals; when it has a team of selected and respected supervisors and has welded them into a supervisory force, sensitized to the needs of their subordinates; when management has educated the individual supervisor's judgment in personnel matters and then solicits, and listens, to the group's judgment of particular situations; when supervisors are free to talk over with their subordinates individual problems and issues before they become group problems, doing so calmly, considerately and clearly, without coercion or job threats; when management has selected a force of competent and interested employes and, through a formal grievance or problem procedure, has given it a means of compelling the practice of the personnel policy, then we have arrived at perfection of personnel management.

The hospital's people as a whole will be doing about 25 per cent more than average work in behalf of the patients and few of them will be thinking about their discontents. Leadership which can successfully compete with this kind of management for the confidence of supervisors and employes is rare.

Perhaps 10 per cent less help will be needed. Service will be friendly and better. Leadership will have become organized and institutional not personal, sustained not spasmodic; those who constitute the supervisory force will have all become able personnel directors, each for his or her department; they, counting themselves favored with fair treatment, will be practicing similar treatment toward their subordinates; management will have protected its people from being called and kept out of work by some distant authority to solve some other management's personnel problems.

By adjusting to some of the subdued but never absent universal ideals, which other leadership often ignores, management will have welded a team of self starters that cannot be turned aside, rain or shine, from its main errand of service to the sick, a team that can go through the valleys of difficulty and can come out on the mountain.

In telling the story of the dungeon job *versus* the white collar-in-overalls job, I refrained from mentioning the questions which it left in my mind. Why did the condition exist and grow for a year? Why didn't 30 foremen on the job see it and paint up and light up? For they, too, were in the dungeon. Why didn't the superintendent of both the dungeon and the white collar departments sense the difference between the two in working conditions? Why did it take a personnel specialist from outside the two departments to look for and find the cause?

Probably this supervisory force had not been sensitized to personnel policies or even to working conditions for supervisors. The management atmosphere may have been such that foremen didn't dare to speak of such inexpensive but emotional factors as the preference of laborers for self respect, for cheerful environment and for the respect of their families, which comes with working in a pleasant environment. The foremen may have been too close to the forest to see the trees.

There was no lack of willingness to correct the condition. But the initiative to find the ailment and the remedy had to come from a person assigned to specialize in this phase of leadership. No outside party could have known there was a problem, much less find its cause. So I say management has the first and best opportunity to furnish leadership in behalf of its personnel. But so important is the task that it should be specialized.

The value of the dollar is being rapidly diluted. The value of other incentives is rising. I have suggested that another 25 per cent of effort is available in the working force of the average organization. It will respond to good leadership. May I add now that this extra effort not only can be gained but must be gained.

Leadership must be taken back into management's hands, but it must be sensitive, consultative, as well as courageous, leadership, and it must concern itself with working conditions. The alternative is neither jobs, nor management nor service to the sick.

Administrative Capsules

• The angle of convergence in coming to focus on a clinical problem is always broad and never sharp.

• If you want to know whether he is a good doctor, ask his students; if you want to know whether she is a good nurse, ask her patients.

• As a sobering experience, every hospital executive should spend the next Hospital Day, or any other day of his selection, visiting other institutions to which he is in the habit of transferring long term (chronic) patients.

• An "acute" hospital for "chronic" patients is the kind of institution we need these days.

• Most physicians cannot get along without the help of the surgeon on occasions, but surgeons should be able to get along without physicians.

• No hospital is worthy of the name these days which does not encourage the various movements that are afoot to make it possible to transfer more and more patients out of charity wards and into the private and semi-private departments.

• Penicillin and the sulfa drugs have saved the reputation of many a careless surgeon.—E. M. Bluestone, M.D.

The PATTERN of BLUE CROSS PAYMENTS

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IN THE early years of the Blue Cross movement it was the general practice to reimburse hospitals for care rendered subscribers on the basis of a fixed per diem rate. This rate of payment was, with probably no exceptions, the same for all hospitals participating in a given plan.

Blue Cross plans developed rapidly and with the marked increase in the number of subscribers admitted to hospitals throughout the country, one began to hear rumblings to the effect that hospitals were losing money on Blue Cross patients. The loss which hospitals experienced, in many instances, was based not on the difference between Blue Cross payments and average per diem costs but on the difference between Blue Cross payments and the amount of revenue which would have been received had the hospital been privileged to charge "established rates."

Have Right to Fix Charges

This means of measuring the financial effectiveness of Blue Cross payments is understandable since it has always been the inherent right of every business to determine the amount it must charge for rendering a service or producing a product. Any organization that loses the right to exercise control over income or earnings may also forfeit its right to continued existence.

The men responsible for the exceptional development and growth of the Blue Cross plans must realize that it is just as important for the voluntary hospital to be financially sound as it is to extend voluntary health insurance to a large segment of the population. After all, Blue Cross is selling hospital service and, without adequate resources, hospitals cannot be expected to maintain the high standard of service needed to ensure the continued success of the plans.

In reviewing the methods now employed in paying hospitals no attempt will be made to mention the minor differences in the technic developed by various plans for the reimbursement of member hospitals. The analysis of existing practices has been based solely on the general principle established with respect to fiscal policies.

At present, 33 Blue Cross plans out of the 87 now in operation are relating their payments to hospitals either to actual billings per individual case or to the average per diem billings reported by each hospital for all Blue Cross patients. With but few exceptions, however, ceilings have been established which determine the maximum amount of Blue Cross payments. Nevertheless, in principle these plans are attempting to relate their payments to established hospital rates.

In addition, 12 plans are paying a fixed per diem rate to all hospitals which is subject to periodic adjustment based on the difference between plan payments and the average income the hospital would have received at established rates. The adjustment in practically all instances represents a pro rata distribution of additional monies to hospitals based on the amount of revenue lost by reason of their accepting Blue Cross patients.

In other words, more than 50 per cent of the plans are now relating their payments, directly or indirectly, to established hospital rates. These plans report an enrollment of approximately 13,000,000 subscribers and it is interesting to note that 19 are located in eastern states, 12 in the West, 10 in the South and four in Canada.

We also find that 32 plans still follow the policy of making equal per diem payments to all member hospitals, irrespective of the differences in cost or billings reported by the various institutions. With but few exceptions, however, these rates are adjusted periodically according to the operating needs of affiliated hospitals.

These plans report an enrollment of 6,400,000 subscribers. An analysis based on the location of the plans reveals that 14 are in eastern states, nine are in the South, eight are in the West and one is in Puerto Rico.

Eight Use per Diem Average

Only eight plans now resort to the use of "average per diem costs" in the determination of the rate to be paid member hospitals. In six of these plans, three of which are located in Ohio, the current rate of payment is based on the average per diem cost reported by individual hospitals. Two plans, located in Detroit and Chicago, follow the policy of paying each hospital either its average per diem cost or average billings, whichever is lower. These eight plans report an enrollment of slightly more than 3,500,000 subscribers.

Information was not available concerning the basis of payment used by one plan located in Louisiana and one in New Brunswick.

It is well known that considerable difference of opinion exists with regard to the "ideal" basis to be used in reimbursing hospitals for care provided Blue Cross subscribers. Any method of payment recommended must be tempered somewhat by the fact that Blue Cross disbursements must be governed by the amount of revenue received from subscribers. Despite this condition, any general policy must provide for a periodic adjustment of payments to hospitals

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in keeping with economic trends. The rapid spiral in hospital operating costs over the last three or four years has focused much attention on the need for an upward revision in subscription rates in order to meet financial demands created by current economic conditions. This situation, in turn, has stimulated state insurance boards in some areas to take a more active part in the determination of the premium to be charged for hospital insurance, as well as the payment that can be made for hospital care.

In the light of this development it is extremely important for hospitals to adopt a firm stand with respect to the policies and principles that are to govern their fiscal relationship with Blue Cross. Any deviation from the initial policy which involved equal rates of payment to all hospitals must take one of two directions, either a payment related to average costs or a payment related to actual or average billings.

So far, the trend has been toward relating Blue Cross payments to hospital billings, although there are many ardent advocates of the principle that payments should be based on average per diem costs.

One of the major issues to be decided is whether it would be economically and financially sound to depart from the principle of receiving established rates for services provided semiprivate patients. The problem now rests squarely with both hospitals and Blue Cross plans and it is important that any decision with respect to fiscal policies be designed to serve as a pattern suitable to both agencies for many years to come.

Public Relations Is Part of the Job of the Medical Social Service Worker

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NEVER before has the work of the hospital been tied in so closely with community affairs, and the medical social worker stands at the crossroads where lines of communication between the hospital and community converge and where traffic is heaviest in both directions. This provides her with a rare opportunity for humane service to socially maladjusted patients of her own institution and of the community at large.

However, the complacency with which we customarily have regarded extramural professional relationships is now a thing of the past. The apple cart has been upset. The whole question of public relations needs rethinking and the development of novel and widened approaches.[1]

Briefly, what is the rôle of the medical social worker as an agent of good will in relation to patients, employes and the public which the hospital serves?

As part of a medical team comprising physician, nurse and medical social worker, she plays an important part in the plan by which total restoration of the patient to community life is accomplished. In these endeavors she skillfully interprets to the physician the social factors bearing on the disease in question and interprets to the patient the objects and purposes of the medical plan as outlined by the clinician. In this capacity she fulfills an essential rôle in maintaining the high quality of hospital medical service so conducive to public understanding and support.

It has been said that in our modern hospital the patient frequently is forgotten for the sake of the disease. One kind hearted person, fearful that too much attention might be paid to scientific problems at the expense of the patient, caused to be written over the threshold of one hospital the motto "Forget the disease and remember the patient." However, concentration on technical problems is indispensable to scientific progress and, hence, a much more satisfactory motto would have been "Study the disease, but do not forget the patient."[2]

This has a special bearing as well on patients in the outpatient department. I do not believe that enough thought has been given to building good will among ambulatory patients. In most hospitals the number of outpatients exceeds by a considerable extent the number of house patients. Yet it is here that the largest confusion often arises.

Long lines of dispensary patients, forced to sit or stand for hours before obtaining examination or treatment, are a familiar sight. Referral to one specialty clinic after another without correlation with the patient's total problem is also a serious indictment of many existing outpatient departments. More consideration, therefore, should be given to the people who attend our ambulatory clinics and who constitute a potent factor in building good public relations.[3]

From a paper presented before the medical social service section, American Hospital Association convention, 1946.

[1] Rubinow, Leonora: Professional Relationships of the Medical Social Worker Outside the Hospital, Tr. A.H.A. **36**:690-693, 1934.

[2] Goldwater, S. S.: "On Humanizing the Hospital," The Hospital in Modern Society, Bachmeyer, A. C., and Hartman, Gerhard. New York: The Commonwealth Fund, 1943, 669.

[3] Ross, T. J. (senior partner, I. V. Lee and T. J. Ross): Public Relations, an address before a forum on Dec. 4, 1945, sponsored by the United Hospital Fund of New York and the Greater New York Hospital Association.

The medical social worker can do much to alleviate difficult situations arising in clinic practice. If a friendly cooperative relationship is established at the initial interview, a basis is established for the patient to return to the medical social worker when problems arise which may interfere with, or prevent, continuity of treatment.

Thus, in such fashions the medical social worker can extend a helping hand as a true angel of mercy to those seeking succor and assistance because of either painful ailments, maladjustment or social distress. By these tokens the sincere medical social worker demonstrates as a practical reality that momentous principle applying to the ethical conduct of human affairs which was expressed nearly 2000 years ago by the Saviour of mankind in these simple words:

"With what measure ye mete, it shall be measured to you again." (Matthew 7:2).

Symbolizes Christian Belief

The devoted and faithful medical social worker symbolizes this attribute of Christian belief. Sympathetic, gentle and kindly conduct is absolutely required for success in medical social work, as with other professional endeavors. Many seemingly insurmountable difficulties vanish completely when individual physicians, nurses and social workers are kind and considerate.

The application of such a design-of-living to relationships with patients, employes and the public as a whole can contribute inestimably toward a public relations program conceived to win the largest moral as well as financial community support. Here, again, emphasis is given to the fact that honest intelligent service of high quality, whether rendered by medical social workers or other divisions of the professional hospital staff, is the essential basis of a well founded public relations program.

In this connection it is of interest to note how the application of this principle actually has worked out in the management of several hospitals. A few years ago I had opportunity to study the amount of free work and charity performed by some of America's foremost hospitals in relation to endowments of these institutions. A wide correlation was found to exist between large endowments and the extent of charity performed. It proved to be the rule that those hospitals which had extended a generous hand to the needy throughout the years of their existence had had the "bread upon the waters" returned many times over through generous gifts and legacies. This, in turn, had made it possible for these hospitals to render an even larger degree of charitable work because of extensive accumulated endowments.

Medical social workers are the instruments by which charity frequently is administered by hospitals and they should be ever cognizant of the far reaching possibilities of the rôle which they play in the application of this momentous social principle.

At this point I wish to say a word concerning the relation of medical social service to employe problems as they bear on public relations. The public interest is involved since "employes represent for the most part the hospital's direct contact with the public it serves. Hospital employes can, therefore, be an active force for creating public good will or ill will, as the case may be. If hospital employes are not 'sold,' so to speak, on the institution for which they work, it is not likely that they, in turn, will do much 'selling' of the institution to the public."[3]

Hospital employes become public relations agents of the institution only to the extent that an effective and favorable personnel policy is in successful operation within the institution. This assumes that tasks performed by employes contribute in some way to self expression, personality growth and development. Otherwise, work cannot be satisfying or meaningful, full of interest and vitality.

The medical social worker has a unique opportunity to contribute to the individual happiness and welfare of employes in relation to a larger personnel program. These factors are basic and highly significant to a favorable public relations program.

Diagnosis of social ills and personality maladjustment is part of the daily problems confronting the trained medical social worker. She realizes that, both with patients and with hospital employes, personal happiness has a close relationship to mental health. She is cognizant, as Atteberry and associates[4] have pointed out, that "personal freedom, consistent with security, is a preventive principle of great significance." Moreover, "tolerance for others, patience and a sincere desire to improve one's self, without admitting necessarily that one is inferior to others, are essential to the acquisition and retention of one's mental health"[4] and happiness.

Medical social workers should be continually alert to detect maladjusted persons among patients and employes. To be well adjusted one should learn to prefer association with others to being alone, should be willing to sympathize with others and ready to cause oneself some little inconvenience for the sake of those in need. One should be considerate of others, not sarcastic or "bossy."

An individual who is eager to "show others up," to flare up when someone unintentionally does something one does not like, or to impose on other people without wanting to reciprocate their favors is not likely to be well adjusted. Social adjustment, above all, involves development of those skills which make social activities enjoyable. Every well adjusted individual should be a lifelong student not only of his own personality but also of the personalities of other people.[4]

The Need Is Recognized

Enlightened hospital administrators, personnel officers and medical social workers are cognizant of the need for having employes well integrated socially. These considerations apply with equal validity to the social problems presented by patients seeking medical aid and social assistance. Moreover, their importance to general community welfare cannot be overestimated. Factors which have a bearing on this social adjustment may be divided into (1) those concerned with the job and (2) those concerned with outside relationships.

The factors that have a bearing on the individual's happiness at work may be enumerated as follows:

1. The desire for intellectual growth and enhancement of abilities.
2. The desire for creative outlets.

[4] Atteberry, George C.; Auble, John L., and Hunt, Elgin F.: Introduction to Social Science. New York: The Macmillan Co., 1941, 267.

3. The need for security.
4. The need for status and position.
5. The need for recognition and approval.
6. The desire for adequate remuneration and reward for services rendered.
7. The desire to share in the accomplishments of the organization.
8. The need for a sense of individual worthwhileness, accomplishment and contribution to group endeavors.

The elements concerned with social integration outside work are also noted:

1. A well adjusted home life.
2. A position in society that gives satisfaction.
3. Adequate housing, food and clothing.
4. Health and physical well being.
5. Adequate leisure and recreation.
6. A sufficient number of friends and acquaintances who are appreciative of one's worth.
7. The opportunity for spiritual worship and growth.

In short, as pointed out by Ordway Tead, "Fundamentally, life to have meaning has to be lived so that all its major occupations and activities contribute vitally and consciously to growth, to self expression and to accomplishment."[5]

This doctrine is basic to successful recognition of individual maladjustments and selection of remedial measures, with application to both employe and patient problems. Psychologic principles underlying maladjustment and social integration are the day to day factors with which medical social workers are concerned in devising satisfaction for normal human desires of patients and others.

Such endeavors are necessary to sustained interest in hospital service and are among the more important factors in developing hospital employes as agents for good public relations. In personnel problems the medical social worker may become a "staff advisory officer" for consultation, "diagnosis" and "treatment" with respect to social problems of employes and others. In this respect she will contribute not only to better medical social service but to better personnel practices and public relations.

There are many other ways in which medical social service is closely concerned with enlightened public opinion, but space will not permit a full discussion of every phase of this subject. Suffice it to say that knowledge of community facilities and resources has drawn the social worker into many public councils. In addition, she has played an important part in many public health programs, including communicable disease control. Moreover, her assistance has been invaluable in plans for the care of the chronically handicapped, such as orthopedic and cardiac patients.

The medical social worker has earned for herself a solid place as an aid to hospital administration whereby her skilled social interviews have been of high value in eliciting information from the patient at a time when he is under special stress. She has cooperated on an extensive basis in medical social research. She has realized her educational responsibilities to achieve the goal that medical students and nurses, as well as medical social workers, are inculcated with sound principles of medical social service. Her standards always have been high and now are an integral part of the American College of Surgeons' standardization program.

But her mission is never ended, nor will it ever be. Her purpose can best be expressed in the words of that eminent statesman, Georges Clemenceau, who said in the closing days of his life: "The great sorrow in the twilight of my life is the discovery that, although I have completed the program of labor laid out for me, I know now that mankind does not find happiness in ending life's work. Happiness comes only in the continuation of work and not in finishing your job."

The medical social worker likewise finds her greatest satisfaction and happiness not in the conclusion of her labors but in a continuation of that noble service which has meant so much to the humanizing of our hospitals.

Throughout the world we are witnessing a growing appreciation of the social implications of medicine. It is essential that we retain the physician's leadership in any program for making medical care available to those in need of it and for ensuring that sound health legislation is adopted. For these reasons it is urgently important that not only the physician but also his allies in related professions be prepared by sound indoctrination for increasing social responsibilities.[6]

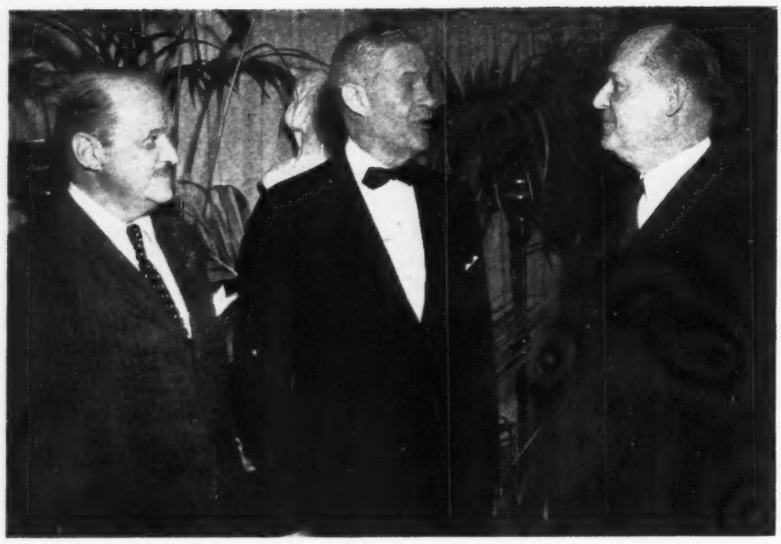
The humanizing influence of medical social service on our hospital system warrants emphasis. The point of view is compelling that only those practices and policies of the institution which are truly in the public interest will contribute significantly to high public relations values.

Favorable public opinion through medical social service can be created only by means of a hospital program administered with gentle, kind consideration of those whom the institution serves, a program that is ever sensitive to community changes and needs.

[5]Tead, Ordway, and Metcalf, Henry C.: Personnel Administration; Its Principles and Practice. New York: McGraw-Hill Book Co., Inc., 1933.

[6]Cannon, Ida M.: "Medical Social Service," Administrative Medicine, edited by Haven Emerson, M.D. New York: Thomas Nelson & Sons, 1941, 159-174.

PEOPLE IN PICTURES



LEFT: Principal speakers at a dinner given by the board of trustees of George Washington University were, left to right: Dr. Claude W. Munger, director, St. Luke's Hospital, New York City; Maj. Gen. U. S. Grant III, chairman of the university's equipment fund, and Robert V. Fleming, chairman of the university board of trustees and president and chairman of the board, Riggs National Bank, Washington.

RIGHT: Dr. Russell H. Morgan, recently appointed radiologist at Johns Hopkins Hospital and University is greeted by Dr. Edwin L. Crosby, left, hospital director, and Dr. Isaiah Bowman, at right, university president.

LEFT: New officers of the Missouri Hospital Association include the following: seated, left: president-elect Edward A. Thomson, business manager, St. Joseph's Hospital, St. Joseph; right: first vice president, True Taylor, Bethesda General Hospital, St. Louis; standing, right: treasurer, Rev. E. C. Hofius, Lutheran Hospital, St. Louis. Standing at left is Mrs. Irene F. McCabe, Group Hospital Service of St. Louis, association secretary. Other officers not shown are: president, Dr. Curtis H. Lohr, St. Louis County Hospital, Clayton, and second vice president, R. J. Connor, Ellis Fischel Cancer Hospital, Columbia. Photograph from "St. Louis Post-Dispatch."

THE HOSPITAL in the CHANGING ORDER

in relation to

Economic Improvement
Industry and Labor
Growth of Cities
Education
Changing Food Habits
Medicine
Group Medical Practice

J. J. GOLUB, M.D.
Director, Hospital for Joint Diseases, New York City

IN LITERATURE and lectures we are told by educators, scientists, sociologists, economists, legislators and commentators that future life will be lived in a social, economic and health world different from the present one. Our attention is called to the growing restlessness of human beings. People move about oftener, travel greater distances over land, sea and air, see more, learn more, teach more, give more, take more, earn more and spend more. They like to be entertained more, judging by the growing number of motion picture theaters and their large attendances.

The era of science and technology has given us incredible speed of travel and has shrunk world distances. Whatever else today's fast traveling people may do, they can also become innocent carriers of germs. A communicable disease in Greece or China can be transmitted within a few hours to the United States and, after the usual incubation period and further contacts, can become epidemic. These facts affect our whole program for the cure and prevention of disease. They affect the hospital's services and its financial resources.

People are also changing their occupations. Farmers are becoming industrial workers. Populations are shifting; cities are growing larger and rural areas, smaller. Education is improving; illiteracy is fast disappearing. Food habits are changing, as is our understanding of nutrition. There are changes in disease incidence: less tuberculosis, fewer other communicable diseases which are cured early by antibiotics, and more chronic ailments. Other trends and changes mark the times, but consideration of the changing order for the purpose of surveying hospital needs and functions can be limited to those which seem most pertinent to the problems and pressures affecting the hospital.

ECONOMIC IMPROVEMENT

The palpable improvement in the economic condition and standards of living of the American people is an important change. It began before the war, lasted through the war years and, in spite of temporary setbacks, seems to be continuing into the postwar period. How long it will continue and when a recession may take place is anyone's guess. At the moment there are no signs of oncoming widespread economic depression. On the contrary, there are evidences that the improved, and even better, economic conditions may continue for several years.

Good economic conditions have already had their effect on the hospital in several ways. They have resulted in a marked decrease in the number of indigent patients seeking medical care in the outpatient service and occupying beds in wards. The effects of these changes are obvious. Outpatient and ward bed facilities need not be increased at this time; in reconditioning hospitals and in new construction the number of private and semiprivate beds must be larger and have a higher ratio to the number of ward beds than in the past.

The alteration of this ratio has a strong bearing on medical education. With fewer ward beds and clinic patients, clinical teaching will have to be done more largely with the cooperation of private and semiprivate

patients. If properly approached, these patients in most instances will agree to have their illnesses serve as an aid to medical instruction.

INDUSTRY AND LABOR

The changes that are taking place in the industrial and labor fields are not without influence on the hospital. Our modern ways of life need and seek out new things; machines and machine-made things require more and more industrial manpower. The trend is toward a thirty-eight to forty hour labor week. More workers mean more industrial and occupational injuries and diseases. More leisure means more time for the worker to obtain medical care. More earnings lead to more frequent and earlier attention to ailments.

Industrial medicine is growing, and industry is recognizing its worth. Labor is more than ever aware of the need for health and medical services for its members. Labor unions are now demanding that employers provide medical service or pay the costs of such service for their employes. All this suggests that there will be an increase in the demand for medical care, as well as for hospital beds. Too, the wages paid to hospital employes must compete with those of industry and commerce. Hospitals will have to meet the trend and pay higher wages, thereby increasing their operating expenditures.

CITIES GROW LARGER

With increasing changes from agricultural to industrial occupations, there is naturally associated a change from mainly rural to mainly urban life. About 56 per cent of the American people already live in communities of 2500 or more inhabitants. One observer states: "Fostered by quick means of transportation, great metropolitan districts came into being, each embracing one or more central cities with satellite towns and farming lands, and these, some 140 in number, contain nearly half of the population."

As a result of the war, the relative and absolute numbers of women employed by industry and commerce and in the professions will remain larger than ever before. The incidence of industrial disease in women will be a factor in hospital planning. It is not difficult to conclude that the larger cities, especially, will need more hospital beds, differently distributed.

EDUCATION

The general educational level is improving at a rapid pace. This leads to better understanding of health as one's greatest asset and disease prevention and early treatment as the ways to attain it. Illiteracy is fast disappearing. The increase in the enrollment in all schools is at a higher rate than the increase in population. There is substantial growth of educational resources at all levels, from grammar school to college, with morning, noon and evening courses on all conceivable subjects. The thirst for knowledge at any age and in any field need not go unquenched today.

These educational gains will continue their influence on medical practice and hospitals. The demand for medical care and periodic health examinations will increase as people gain in knowledge and become informed. Hospitals must prepare now to meet this changing condition in its special aspect of the entire field of health service.

FOOD HABITS CHANGE

Food habits are changing. The preparation of foods increasingly includes canned, frozen, dehydrated or concentrated products. Vitamins issued over the counter and prescribed by physicians are a new factor in nutrition.

Food is easy to produce by the country's great agricultural resources and modern farming technics. It is easy to distribute by ever-improving transportation facilities. It is easy to consume by populations growing in number and with improved earnings. Yet, even before the demands of a hungry world brought drastic new changes in our food economy, diets for a large segment of the population for the most part ran counter to the knowledge and experience of present day nutrition and medical science.

The fact that more than half of the world's two billion people are underfed is explained by local shortage of foodstuffs and poor transportation facilities and, of course, today by the devastating after-effects of war. But in our country, where food supply is abundant, the occurrence of malnutrition is inexcusable.

Nutrition is related to consumption levels, to dietary content of essential nutrients and to balance. It is related to the income of the individual and family, to the price of food, to the degree of popular knowledge of intelligent food selection and to the food supply in places where it is needed.

However, the relationship of nutrition to disease is primarily a medical responsibility. Further studies of that aspect of the problem will increasingly be carried on by medical men, physiologists, chemists and dietitians in hospitals, and appropriate research and clinical facilities will have to be provided.

MEDICINE AND HOSPITALS

The realization is emerging that health problems outrank all other domestic problems vital to the life of the people. Interest in the matter of maintaining and conserving health has reached unprecedented heights. Legislators and national and local organizations are devoting major efforts to health problems. Broadcasting systems, lecturers, newspapers and medical and other publications are focusing attention on the advances in medical science and on man's health status. Their concern is with housing, clothing, nutrition, recreation, prevention of disease and medical care.

Recently, the American Medical Association announced a national health program to be organized by voluntary effort as an answer to the national health program included in the various bills that have been taken under consideration by the Congress. Many state and municipal governments are working on local health plans, as are local voluntary agencies. Interest is growing and activity is being intensified.

Health problems will be a balanced responsibility of governmental and voluntary agencies. All these plans and activities concern the more than 150,000 practicing physicians, the more than 6000 hospitals and the several hundred thousand nurses and hospital workers in the country. Above all, they concern the 4.5 per cent of the people of the United States who are ill or physically disabled every day.

Thus, more than 6,000,000 people at any moment are unable to work, attend school or pursue their other usual activities. They should have the opportunity to benefit from the advances in medical science and service, which include hospital facilities equitably distributed in all parts of the land.

Medical science is on the march at a speed never before equaled in history. We scarcely have time thoroughly to apply and test one drug, one measure or one modality before we are furnished with another and soon with still another. A striking example, of course, is the introduction of sulfa drugs, followed by penicillin and again followed by streptomycin. Another example is the changing method of blood transfusions, the phenomenal classification of the blood types, the introduction and widespread use of blood banks and substitutes for blood and plasma.

Great impetus was given to this field when the blood bank system was introduced, making blood of all types and blood plasma immediately available at all times and for all emergencies without waiting for the arrival of a blood donor. The war also focused attention on the therapeutic and lifesaving values of transfusions; physicians returning from military service are more conscious of these values, and a greater use of blood plasma will be made in the years to come for a larger number of conditions.

In the light of these trends, which increasingly involve highly technical laboratory procedures and studies in hematology, hospitals will need to designate more space, provide more equipment and engage personnel qualified to deal with the clinical laboratory and research problems involved in this field. Similar changes must be made to adjust to new advances in antimalarial pharmaceuticals, in the application and use of radium, deep therapy with 100,000,000 volt x-ray machines, high powered microscopy and, finally, the release of nuclear energy resulting from the research done on the atomic bomb.

Important advances in such fields as shock therapy in psychiatry, encephalography and neurological and chest surgery will also bring changes in hospital design and operation. For these and others, the hospital must be prepared to provide more space, equipment and money.

GROUP MEDICAL PRACTICE

Rapidly growing membership in hospital, health and medical care insurance plans has long exerted an important influence on hospital service. The trend toward group medical practice is also gaining momentum. Increasingly, groups of physicians of several specialties, independently or around a hospital, systematically associate themselves into a group, with central offices, joint use of diagnostic and therapeutic equipment and administrative, nursing and technical personnel.

Many members of the medical profession, through national organizations and local societies, have questioned the claims made by protagonists of group medical practice. They feared the possibility of commercializing medicine, of disturbing the sacred relationship between physician and patient, of destroying free choice of physician, of retarding the proficiency of practitioners and advancement of research. They saw in it a threat to medical ethics and, above all, they feared it would ultimately lead to governmental control.

Advocates of group medical practice point out many advantages to physicians and patients and regard it as an economical way to furnish medical care at high standards of service. They argue that it gives an integrated service in one fully equipped and ably staffed place; patient-physician relationships are unaltered; free choice of a group and free choice of physician in a group by the patient is the policy; consultation service by specialists is immediately available; there is ample opportunity for young physicians to learn medicine and gain experience.

In addition, proponents of group practice assert it results in improvement of diagnostic, therapeutic and preventive services over those now received by many people at the hands of practitioners and specialists in their separate offices. The sharing of offices, equipment and personnel results in economy to physicians and patients. The physician with an assured income does not have to work long hours day and night, is able to take vacations and has time and money for postgraduate study.

Of late, articulate opposition to group medical practice has been diminishing. It is gaining in popularity among both nonmedical and medical people. Obviously, there is a growing change of attitude among medical men. An inquiry by a committee of the American Medical Association among physicians in uniform in 1944 found that 53 per cent of doctors of all ages wanted to go into the group form of private practice, and 63 per cent indicated a preference for a form of practice other than the traditional form of solo practice on a fee-for-service basis.

This trend is also noticeable in the recent action of the coordinating council of the county medical societies of New York in respect to the medical practice groups that are being set up by the Health Insurance Plan of Greater New York as a means of rendering the comprehensive service of medical care to subscribers of that plan.

The establishment of medical practice groups raises problems related to hospitals. Since groups can operate around or within a hospital, or entirely independently of a hospital, the hospitalizing of insured patients by physicians in an independent group which has no hospital affiliation again brings up the old question of open staff *versus* closed staff in hospitals. Wishing to encourage their own staffs to create a group, some hospitals may offer office space and use of diagnostic and therapeutic services. This is a great convenience to staff physicians and patients and results in economies of equipment and maintenance.

Change is a law of life, and to cope with change adequately is a challenge to the living. This aphorism is equally applicable to institutions, whose many phased and complex procedures and services are performed by people for people, though in many instances with the aid of special and technical equipment and precision instruments.

The effects of the changing world on medical care in general and on hospitals in particular are so marked that a critical examination of its aims, functions and operations seems called for in every hospital today.

This is the first of three articles by Dr. Golub on the changing responsibilities of hospitals. They are based on a survey and recommendations he made for the Hospital for Joint Diseases of New York. The next will appear in an early forthcoming issue.—Ed.

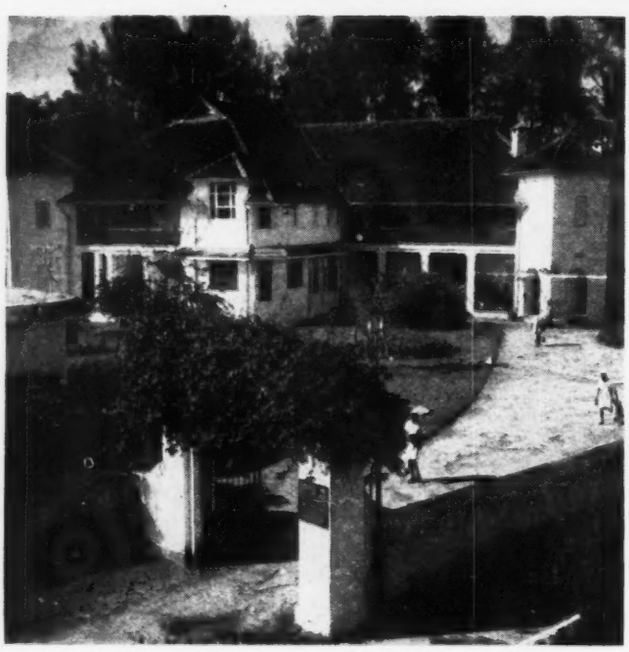
HOSPITAL AT

THE Zanzibar Hospital, with European, Asiatic and African sections, is one of four government hospitals of the East African island colony, Zanzibar, which celebrated the bicentenary of its ruling Arab dynasty in 1944, has been a British protectorate since 1890 and is ruled by a sultan with the assistance of a British resident.

In 1944 the four hospitals had an approximate attendance of 351,000

ABOVE: On her daily inspection tour, the matron stops in the women's ward to inquire how the patients are getting along. RIGHT: P. Patel (left), head dispenser of the pharmacy, watches one of his two assistants, Ahmed Aley Said. All preparations for the hospitals and for the 16 dispensaries on the island are mixed here.

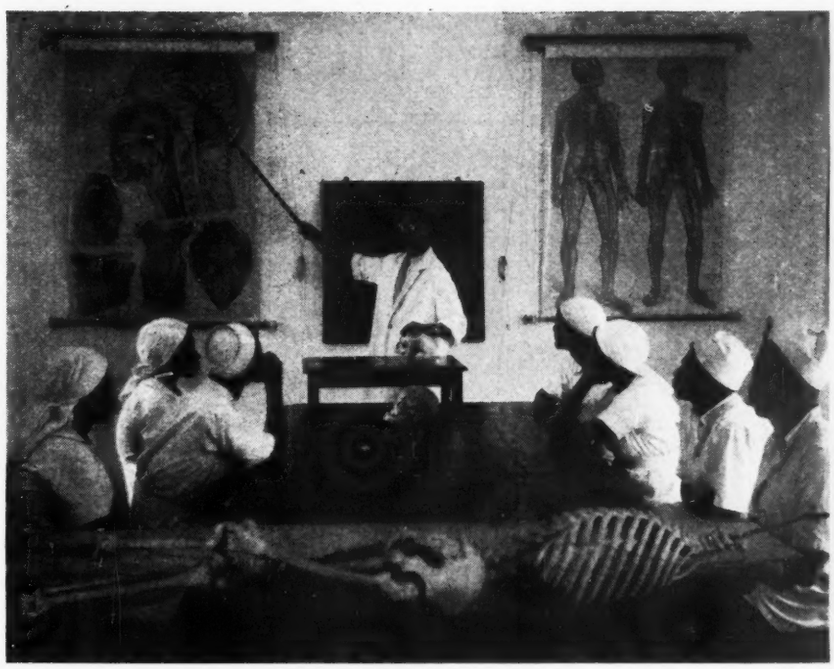
BELOW, LEFT: The hospital comprises a European section, an Asiatic section and an African section. Pictured here is the entrance to the European section. BELOW, RIGHT: A prospective patient at the biweekly baby clinic looks a little doubtful about the idea of letting the clinic's examining nurse, Sister Main, put him on the scale.

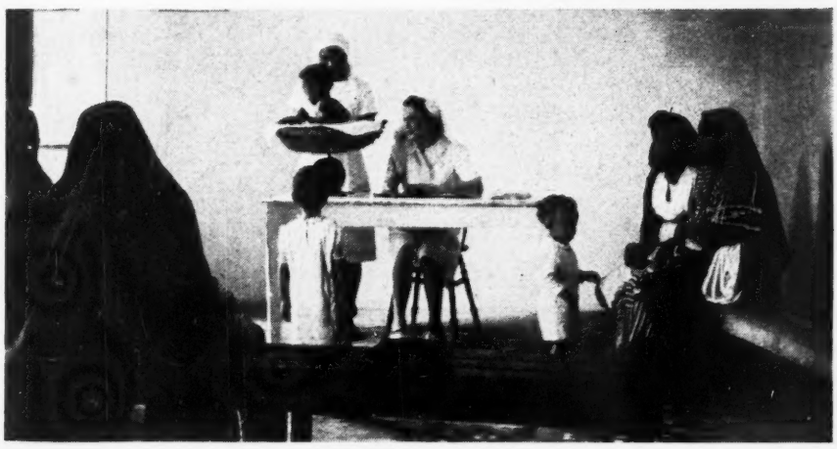


AT ZANZIBAR

patients. There are also six maternity clinics, an eye clinic, a mental hospital and a school of medical and dental service.

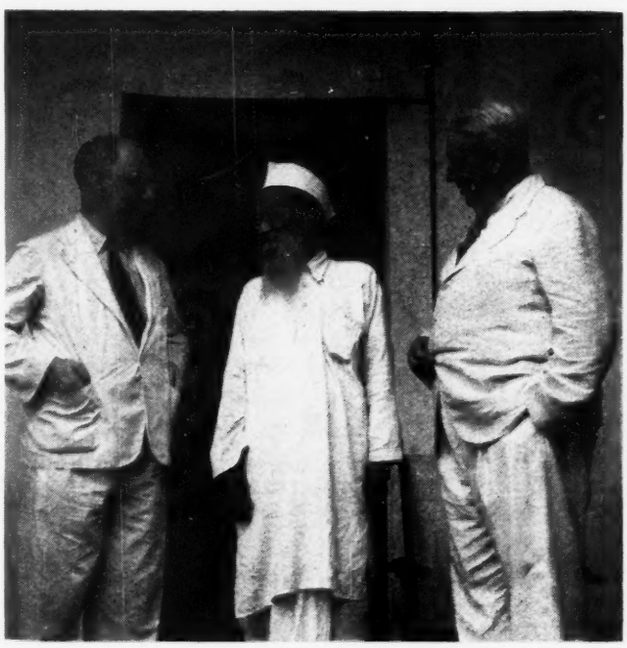
Grants are made from the British treasury to train local personnel as hospital attendants, nurses and health inspectors. Its postwar development plans include the erection of hospitals and development of medical services at an estimated capital of $920,000 over the next few years.





ABOVE: Said Mahfuth, assistant medical officer, gives a lecture in anatomy to nurses, midwives and attendants. These women are trained not only for the hospital but for units in Pemba and for maternity centers which are to be established in the country districts. BELOW: Hadija Salim laying out the instruments for an operation. She serves as theater sister and has received full training in the responsibilities of her position.

ABOVE: Mothers learn the value of health and hygiene. BELOW: Two doctors on the Zanzibar Hospital staff talk with a patriarchal Indian patient.



SMALL HOSPITAL FORUM

Keeping Up With Maintenance *Keeps Small Hospitals Busy*

MANY hospital plants are in rundown condition as a result of the long wartime period during which it was impossible to get equipment or labor, or both, a survey of small hospital building maintenance problems reveals. At the same time, more than half the hospitals responding to the forum on this subject report their plants in first class condition, with no major repairs or replacements needed.

Specifically, nine of 15 hospitals queried report plants in good general condition. Even in this group, however, a few major maintenance expenses are pending, such as new flooring, elevators, plumbing and heating systems.

In the group as a whole, needed plant improvements are reported as follows: floors, 4; heating system, 3; remodeling, 3; painting, 2; elevators, 2; plumbing, 1. Estimates of the amount of time that might be needed to complete these plant repairs or improvements vary from six months to two years. The average time stated is slightly more than a year.

In addition to these plant improvements, five of the hospitals report major equipment replacement needs. Sterilizers and food conveying equipment head the list of needed items; others mentioned include dishwashing and refrigeration equipment, stoves, operating room lights, x-ray machines, washers, driers and ironers and laboratory equipment. Several hospitals also report the need for extensive replacement of furniture.

Every hospital queried follows, or at any rate attempts to follow, a systematic schedule of building and equipment inspection, so that maintenance effort can be directed primarily at preventing breakdowns instead of just doing needed repairs.

"It has been hard during the last three years to keep up," one administrator comments, explaining the failure to keep on schedule which was also acknowledged by several others, "but now, with a little more help, we are really endeavoring to follow our inspection schedules closely."

Probably the most notable fact about the inspection schedules reported (see accompanying table) was the fact that nine hospitals do not indicate any scheduled time for inspecting motors, wiring, outlets and other electrical equipment, items which most engineers agree should be carefully examined on a regular schedule to forestall expensive breakdowns. With this exception, the hospitals reporting show fairly uniform schedules of inspection—usually on a monthly or quarterly basis—of sterilizers, plumbing, heating lines, steam traps and valves and other equipment. Half the hospitals include beds, chairs and other furniture in the list of equipment that is regularly inspected for maintenance needs. The others depend on nursing or housekeeping personnel to report furniture repair and replacement needs as they develop.

Nine of the hospitals in this group have all furniture repairs made outside the hospital, at an annual cost which runs up as high as $1000 (in the case of one hospital in the 50 bed classification). While the six hospitals that do their own furniture repairing report generally lower annual cost, there is no fair basis here for comparison because of the variations in size of hospital and age and type of furniture.

One administrator does comment, however, that after trying both methods he has found it more satisfactory to set up and operate his own repair shop. "It's cheaper and quicker," he says.

EQUIPMENT INSPECTION SCHEDULES IN 15 HOSPITALS

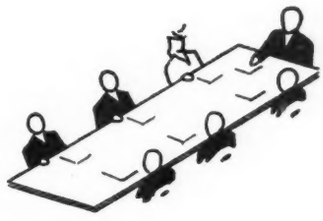
Equipment	*Daily*	*Weekly*	*Monthly*	*Bi-Monthly*	*Quarterly*	*Semi-annually*	*Annually*	*Not Stated*
Electric heaters, wiring			5		1			9
Sterilizers	1	1	3	2	4			4
Plumbing	6	1	3	1	4			
Heating lines			4	1	1	2	4	3
Steam traps and valves		1	3	1	3	1	2	4
Other major equipment		2	3	1	1	1		7

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
Homestake Hospital, Lead, S. D.	R. B. Fleeger, M.D.	25
Sacred Heart Hospital, Idaho Falls, Ida.	Sr. M. Victoria	28
Memorial Hospital, Burlington, Wis.	Lucille Rossmiller	35
Ellsworth Hospital, Ellsworth, Kan.	Corinne Hamilton, R.N.	45
H. B. Magruder Memorial Hospital, Port Clinton, Ohio	Mabel Selin, R.N.	50
Utah Valley Hospital, Provo, Utah	J. H. Zenger	50
Community Hospital, Medford, Ore.	Phyllis Swearingen	52
Kennedy Deaconess Hospital, Havre, Mont.	Lela M. Diefenbaugh, R.N.	60
Kent General Hospital, Dover, Del.	Dorothy Mathews	60
Ellen Fitzgerald Hospital, Monroe, N. C.	Edna M. Clark, R.N.	60
Miriam Hospital, Providence, R. I.	Genevieve Nesby	63
Alhambra Hospital, Alhambra, Calif.	D. L. Braskamp	65
King's Daughters' Hospital, Brookhaven, Miss.	Howard Anthony	75
Culver Union Hospital, Crawfordsville, Ind.	Ralph M. Haas	85
Hartford Memorial Hospital, Havre de Grace, Md.	Robert S. Hoyt	104

Who Shall Pay for *Nursing Education?*

THE PUBLIC



AS EVERY hospital administrator knows today, many changes are coming in the nursing profession in the next few years. What happens in nursing education, especially, is critically important to all hospitals, and what happens will necessarily be governed in large measure by financial considerations.

This discussion of the basic question, "Who shall pay for nursing education?" took place at the biennial nursing convention in Atlantic City in the autumn. The participants are Ruth Sleeper, president of the National League of Nursing Education; Dr. Luther Gulick, moderator, president of the Institute of Public Administration; Dr. A. J. Brumbaugh, vice president of the American Council on Education; Dr. Esther Brown, director of studies in the professions of the Russell Sage Foundation; Agnes Gelinas, chairman of the nursing department of Skidmore College, and U. S. Senator Claude Pepper of Florida.

A condensation of the discussion appears in the following pages. The full text is published in the January issue of the *American Journal of Nursing*.—THE EDITORS.

MISS SLEEPER: The pioneers in nursing education called attention to the need for a sound economic basis for schools of nursing. The leaders in nursing education continue today to urge both consideration and action to meet this need, but the voices of women are easily drowned out in the many calls for the support of hospitals and other types of educational institutions. This problem is not one to be dealt with by nurses alone, nor is it one for nurses and hospitals and universities which now support nursing education. It is a public problem to be studied and solved by the community with the best possible advice from the lawmaker, the economist, the educator, the hospital director, the doctor, the citizen consumer and the nurse. Such a group has joined us to consider this topic, "Who Shall Pay for Nursing Education?"

DR. GULICK: To start the ball rolling I am going to ask Dr. Brown what she thinks the major issue is in the whole field of nursing education.

DR. BROWN: It seems to me that one of the most important questions at the present time in nursing education is how we can provide a scientific training which is thoroughly educational and which will give the student a knowledge of science both in its principles and in its technical applications. I should like to include under science not only the physical but the social sciences. The question arises of how that training in scientific method and its application, in both the physical and the social sciences, can be provided to the best advantage.

DR. GULICK: Let's turn now and ask someone else if he wants to identify a major problem to place beside this question which we have just had from Dr. Brown. I wonder, Senator Pepper, if you want to throw in a point?

SENATOR PEPPER: Well, I think one of the basic questions is to determine whether, if at all, and to what extent the public must provide part of the support of nursing education.

DR. BRUMBAUGH: I should like to suggest two questions, Mr. Chairman. There is one which I think the profession must face very directly, namely, that of the selection of candidates in terms of aptitudes for nursing and of general competency for that field. As I have observed the training programs there has been a large attrition, and I think it has been due in part to lack of satisfactory selection in terms of adequate criteria. The second question relates to the organization of the curriculum, the relationship of practical experience or laboratory experience, if you please, to the theoretical in order to make it strictly educational rather than a service function in relation to practical aspects of nursing itself.

Miss Gelinas: I would like to say that the undergraduate nursing education in this country is largely on a profit-making basis. Through service and with cash, students in many instances are contributing an extremely high percentage of the cost of the school of nursing. The schooling provided thousands of students of nursing is so inferior and so limited that it leaves them unprepared to meet the demands made upon them as graduate nurses. The areas, I think, which need strengthening are in the fields of tuberculosis, psychiatric, communicable disease and public health nursing.

Miss Sleeper: One of the big issues which we must face is the interrelationship of the nursing service and the school of nursing, the dependency of the nursing service upon the school and the dependency of the school upon the hospital where the nursing service is given; and when we think of this interrelationship we are immediately faced with a second issue. If the student is in a hospital to learn, where does learning end and where does service begin?

Dr. Gulick: I want to add one question to this total list that we must never forget, and that is your public. What about the public? The public wants good and competent nursing. The public knows that good and competent nurses can't be had without proper education, proper support, proper devotion of individuals to the career of nursing, and yet, on the other hand, the public is always short of funds and income, and there are large segments of the population that need nursing that can't pay for it, that are eager to have the costs kept at the lowest possible point and yet realize that even that isn't adequate to meet the full costs.

That brings us to the next series of questions as to the financing of nursing education, and I am proposing that we will discuss first how nursing education is paid for today. Here, again, I am going to turn to the members of the panel. This time I am not going to call on anybody specifically, but let anyone volunteer who wants to outline some of the present methods of financing nursing education in the United States.

Miss Sleeper: There are about 6 per cent of our 1200 plus schools of nursing in universities. Those schools would therefore be supported like other university schools are supported, through endowment, through tuition fees of students and, if they are state universities or city colleges, through tax support. The other 94 per cent of our schools of nursing are in hospitals. Some of those schools of nursing have some support from endowments, but that is on the whole very meager, and the number with endowments of any size is very small.

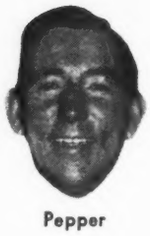
The schools are supported to a small extent through the tuition of students and to a large extent through the services which the students themselves render as they give nursing care to patients. And I should like to emphasize, to be fair to the hospital, that a part of that nursing care is laboratory or learning experience of the student. A large part of that care—and where the learning ends and where the service begins we do not know—but a large part of that patient care is contributed by the student beyond the point of having learned her procedures and is a direct income to the hospital and to the school of nursing.

Dr. Gulick: Are there any other types of contribution that should be included as the basis of financing of nursing education in the United States today? Are there any of the hospital schools that receive tax support today?

Miss Sleeper: The city, county and state hospitals would come in that group.

Dr. Gulick: We seem to have quite an unusual situation in the education of nurses as compared with other professions. How do we train other professions in the United States? I think, Senator Pepper, this might be a point you would like to say something about.

Senator Pepper: Well, of course, in both publicly and privately supported institutions other professional people are trained. I think it very pertinent that we should have also the same kind of institutions for the training of nurses. Engineers, for example, are trained in universities in the several states and in private engineering schools. Universities are supported by public funds in most cases. Private institutions are supported generally by gifts and by tuitions and by endowment. The



Pepper

same thing is true with respect to lawyers. The same thing is true with respect to doctors. So that, generally speaking, other professional people to a considerable extent have the facilities supported by public funds which make professional training possible for them, other than support for board and lodging during training, which is customarily furnished by the individuals and their families.

Public support for education must rest on the premise that the care of health is a matter of public concern. Health care should be financed like education if our people are to get adequate nursing care. Nursing education should be financed like other professional education.

Dr. Gulick: There are certain other professions that I think might also be mentioned. What about some of these new activities in the fields of nutrition and social work?

Senator Pepper: I think in those fields it is again mixed. Some are educated in publicly supported institutions or they get public aid. In other cases they are privately supported.

Dr. Gulick: When we talk about private educational institutions in America, I think it is unfair to think of a private educational institution as not a public institution actually. It is tax exempt. We maintain it. We organize it under the law; we supervise it through departments of education. We give all sorts of special privileges to the institution because that is part of the American way of providing for higher education, and if people of means wish to make gifts to such institutions we exempt them from taxation.

These institutions, though we call them private—like Yale and Columbia and Princeton, and the western and southern universities—though we call them private, actually, this represents just another method of providing education which the public regards itself as responsible for giving. So that I think we want to see clearly, when we talk about public and private, that the so-called private educational institution in America has a public responsibility

which it recognizes and tries to meet in its educational program.

DR. BROWN: Practically all of professional education, as far as I know, has now come within the aegis of the college or the university. It happens that in certain professions you still have a few proprietary schools left. They are the remnant of something that is rapidly passing off the scene.

DR. GULICK: What do you mean by proprietary schools?

DR. BROWN: For instance in medicine, in 1921 when the Carnegie Foundation made the great study of medical education, probably more than half of the medical schools of the country were privately owned, privately operated medical schools, some of them reasonably good, a great many of them disgracefully bad. Now today there is scarcely a medical school which is not an integral part of a university.

The trend has been perfectly clear. The privately owned, privately operated school has been unable to meet the exigencies of education which has become increasingly more expensive, which has increasingly made larger demands. So the university has taken over as the one institution, in most of these instances, which was equipped to provide what needed to be provided to render adequate professional education.

DR. BRUMBAUGH: I would like to comment on what Dr. Brown has just said. I would hope that Dr. Brown's remarks would not be construed as tolling the death knell of the private colleges in the United States. I think there should be a clear differential made between the private proprietary, which is a profit-making institution, on the one hand, and the nonprofit institution which, as Dr. Gulick has pointed out, is public in its service but private in its control. And I should like to point out in that connection that in the teaching profession until recently at least about half of the teachers in the secondary schools, and somewhat less than that in the elementary schools, came from the private colleges of the United States. We need to keep those in the picture from the standpoint of a distinctive type of service.

DR. BROWN: Before we had proprietary schools we had apprenticeship training in practically every profession. If you wanted to be a doctor you attached yourself to a practicing physician. If you wanted to be a lawyer you attached yourself to a practicing lawyer, and so it went. You read whatever books were available. You watched the practitioner doing his job. He gave you things to do. He supervised you in both your reading and your practice as much as was possible. But you know perfectly well that that kind of a system is not adequate for very long.

It is only when a society is very new or a profession very rudimentary that that is at all an adequate solution. Consequently, as time went on we saw very clearly that no private individual could give either the time, the skill, the money, the equipment or the breadth of vision which was necessary for the training of a professional person. But as apprenticeship began to wear itself thin, the proprietary school appeared.

The doctor, for instance, who had had one student under him in training decided that he might take six or eight or 10 students. So he got a little building and perhaps he got an assistant or two. Then he let it be known that he would take, for a specified remuneration, a certain number of students. The same thing was true in law, and the same thing was true in practically every profession in its early stages.

I think the trend has been quite clear in most of the professional fields that we began in a rudimentary way with apprenticeship training. We frequently passed into the era of the proprietary school, and then we eventually passed into the era where we are today, where most of our professional schools are under the control and the supervision of the college and the university, whether they be privately or publicly financed.


Gulick

DR. GULICK: There is one thing that comes up in this connection that is quite interesting to me and that is this: How do you know when a given line of work is going to grow up into a profession? How do you know when it has the basis and the content that make it legitimate to call it a profession?

MISS GELINAS: Well, I think when that line of work has a body of scientific principles underlying its technics; and I think also it becomes professional when it has a definite public service content. In other words, if those people are serving the community and if they have a body of knowledge that is theirs, based upon scientific principles, I think then that you can say that they are in the professional group.

SENATOR PEPPER: The statement made by Dr. Brown and the definition of profession which has been given by Miss Gelinas should lead us now to the conclusion that the nursing profession has grown up enough to get into the same category in which other professional training schools are. Nurses shouldn't any longer, to any serious degree, be treated like lawyers who used to read law in a lawyer's office or like students who learned medicine along with a doctor in his office. There should be set up appropriate educational institutions to teach people and train them in the profession of nursing; we have come to the stage in the evolutionary process that Dr. Brown has so well told us about where people who are trained in the nursing profession are entitled to go to a nursing school which uses the hospital as a laboratory but not as a place where you do chores.

Nursing education must become part of the curriculum of our recognized higher institutions. Its professional character and face must be lifted to that level. It should not be wholly part of our hospital system to which most of our schools of nursing are attached; however, there is no reason why nurses should not serve internship like doctors and other medical personnel.

DR. GULICK: We have reached a pretty clear agreement that nursing has come of age as a field of occupation in which there is a body of scientific knowledge which can be passed on through the educational process; that there is a conscious feeling among the members that they constitute a profession, a feeling of responsibility to the community, a feeling of responsibility for the discharge of their functions.

DR. BRUMBAUGH: Mr. Chairman, may I ask if that suggests also that an added element of this conscious-

ness on the part of the profession itself is that certain minimum standards are set either by the profession or by agencies that determine qualifications for the profession which must be met before an individual participates in that particular professional activity?

DR. GULICK: Yes. And I think it is also true, isn't it, that in all of our professions we have a rather important ceremony, you might say, on the induction of the individual into the profession. That is part of the consciousness of the existence of the profession. The doctors take their oath. The lawyers go through various specific requirements and are admitted to the bar. Those who go into the teaching profession take their specific degrees in very important ceremonies with long black robes from the Middle Ages. So that the consciousness of the group and its sense of responsibility, the necessity of meeting certain standards, the scientific content of the work—all those factors are present now in graduate nursing.

Gelinas

MISS GELINAS: I should like to bring out one other point. The professional knowledge should become public knowledge and, therefore, we can call it public education; and in this country which believes so strongly in public education and supports public education in the other fields, certainly nursing education should receive as adequate financial support as medical education, social service education and teacher education.

DR. GULICK: If we recognize that education for nursing has now reached this point, we come to the question of how should it be organized, how should it be set up, and how should it be financed? Do you think, Dr. Brumbaugh, that nursing education should be carried on primarily in our public institutions because of this great public interest, or should the private institution also be concerned with it?

DR. BRUMBAUGH: Mr. Chairman, I come back to the point that you made that the private institutions are primarily private in control but public in function. Being private in control they are in some respects freer to experiment and to blaze the trail educationally than are institutions under public control. I would therefore certainly hope that private institutions might be active participants in a program of nurses' education as they are in programs of education in other fields.

The point I wanted to make, more particularly however, relates to the suggestion made by Miss Gelinas that the institution should be publicly supported. If we say that the institution should receive public support, federal or state, we immediately raise a question of policy with reference to a great many states where there are statutes forbidding public funds to be used by private institutions, going back to the earlier belief that religious institutions particularly should be independent from the state.

DR. GULICK: I wonder if any member of the round table has the feeling that nursing education should be confined to public institutions or private institutions, or do we need both of them in the field?

MISS SLEEPER: I think there is no doubt that we need both types of institutions and both types of support for institutions. There are now employed in government hospitals some 60,000 nurses and in state health agencies some 15,000 nurses. If we are to have a total of 75,000 nurses employed in tax supported institutions, it would seem only right today that tax supported institutions should carry their share or, if I put it the other way around, that tax support should be given to institutions which are to prepare nurses. On the other hand, a large number of nurses are employed in private agencies, hospitals and health agencies, and those hospitals and health agencies should also carry a share of the preparation of the nurses whom they are to employ. In other words, it should be both private and public.

DR. GULICK: I wonder, Senator Pepper, in view of these figures that we have just heard about the number of nurses employed in tax supported institutions, if you anticipate that in the years that lie ahead government programs are going to call for a larger number of individuals trained in nursing.

SENATOR PEPPER: Oh, unmistakably so, Mr. Moderator. For example, just before the Congress recessed we added about $10,000,000 of funds to the Children's Bureau for maternal and child care, for crippled children and for child welfare. There will be more nurses required in the carrying out of that program.

We also enacted the first National Mental Health Act. Unfortunately, we have neglected that field of illness too long.

I should also add to the legislation that has recently been enacted the Hospital Survey and Construction Act. That allows $75,000,000 a year for the next five years for the construction of hospitals over the country. I regret to say that some of our people who thought they were saving federal money imposed the condition that the federal government would put up only one out of every three dollars spent for hospital construction. I now understand that officials of one state have already protested that they would not be able to meet their matching requirements of putting up two state dollars for every one federal dollar. No one knows better than the nurses that the need is often greatest in the areas where the means to meet the needs are least.

In addition to that, we have under consideration for the future the Wagner - Murray - Dingell National Health Bill. If that should pass, of course, it would be the principal task of that system to provide medical and laboratory, or hospital and some dental and a great deal of home nursing care to the majority of the people in the United States, more than one hundred million of our population, and no one can estimate the number of thousands of new nurses that would be required for that.

Senator Murray, Senator Morse and I have introduced a bill which contemplates a ten year program of educational assistance. That bill could be interpreted to include nursing education as well as the other kinds of education that are embraced within that bill. Incidentally, that allows aid to private schools. I am thoroughly in accord with what has been said that a method can be provided by which aid can be given to private institutions, under proper safeguards, as well as to public institutions.

I will be sorely disappointed and society in this country will grievously suffer if we don't more than

double the number of nurses we now have in the next five years.

DR. GULICK: And I am wondering, Senator, what happens to all this legislation for the benefit of mothers and the children, and thus for the whole population of the country, if we don't have competent administrators, competent medical service, competent nursing service and other competent administration to carry out and enforce the legislation; what happens to all the good work?

SENATOR PEPPER: Without the administration the laws fail. I think that everybody agrees that the nurse is an essential part of competent medical care, and without the nurse the doctor cannot give adequate medical care to the patient.

Now, I think it will be probably true that we will have to train a certain number of practical nurses who will be able just to provide care, largely to assume the rôle of attendant to the patient; but it is important that we start nurses to aid in this program right away, because we are going to pass legislation faster than nurses can adequately be trained if we don't speed up our training processes.

MISS GELINAS: We are all aware of the shortages that exist now in nursing and I think, too, that those of us in the profession are aware of the inadequacies of some of the schools that now exist. Some of the small poor schools of nursing must be closed. Taxation money, if it is to be made available, should be given to the good schools of nursing, the accredited schools of nursing, and the schools that have available to them rich clinical facilities, because those of us in education certainly realize that we need an immense improvement in some of the schools of nursing that we have in this country.

DR. GULICK: I wonder, Dr. Brumbaugh, if you think that the clinical aspect of nursing education, that is, the utilization of practical experience in a hospital and in other situations is an important part of the education.

DR. BRUMBAUGH: Mr. Chairman, I have worked in the field of general education for many years. I am thoroughly convinced of the indispensability of so-called practice teaching or apprentice teaching as a part of the preparation of the teacher. I think it is impossible to have an individual get the point of view of the classroom, to understand how children respond in a learning situation, unless he actually works in the situation that is representative of his own professional objective.

I think it is equally as true that laboratory experience must be an indispensable part of the training of the nurse. I should like, however, to stress the fact that laboratory experience must be focused wholly upon professional training and must have educational significance in terms of that professional training. If the experience goes beyond the point of educational significance it means that an individual is being exploited for a noneducational purpose in an institution rather than having all of the experience focused upon an educational objective. That is one of the difficulties that I have observed in programs of nurses' education at the present time. There isn't a clear distinction between that indispensable kind of laboratory experience that is an inseparable part of good training and that service experience that goes beyond the indispensable aspects of training.

SENATOR PEPPER: Dr. Brumbaugh, I am sure we have the same idea about the necessity of laboratory experience in any professional training, but in the training of the doctor we don't have the medical student go to work in the doctor's office and sweep it out in the morning and fold the doctor's mail for him and try to help him collect his bills and go home and visit the doctor's family in case of an emergency, and so on. The student goes to a doctor's office or he goes to a hospital as a part of his regular curriculum unless he is so poor that he has to get work somewhere.

So I know that when you say that the laboratory is essential, you mean that laboratory work—and, of course, that means to a considerable degree work in a hospital—should be a part of the curriculum. But you don't necessarily mean that the students should all have to do these chores.

DR. BRUMBAUGH: I thoroughly agree with you, Senator, and that is exactly what I had in mind earlier when I said that we need to review the whole curriculum of nursing education. I am inclined to think that there is a lot of water in terms of this routine dusting up and cleaning up type of activity in the curriculum that could be squeezed out and the curriculum be made much more professional in character within the same time limit as at present.


Sleeper

MISS SLEEPER: I have before me Pfefferkorn and Rovetta's "Administrative Cost Analysis of Nursing Service and Nursing Education." I think it is interesting in relation to this discussion to cite three schools very briefly. At the time this study was made, at these three schools, the costs of care of the student, maintenance of the student, care while she was ill, support of the library and the entire educational program per student ranged per year from $570 to $747, and of those amounts, only one sixth went toward education.

Now, clinical education may be expensive education, but it is not expensive in the way it is being given to student nurses today in many schools. Miss Pfefferkorn's study reemphasizes the fact that about one sixth of the total expenditure for the nursing student is spent for general instructional purposes. I I wonder if Dr. Brumbaugh can tell us what part of the total expenditure per student is spent for general instruction in colleges and universities.

DR. BRUMBAUGH: I can't give a precise ratio off hand, but usually administrative and general maintenance costs in a college or university will constitute between 40 and 50 per cent of the total budget, which means that about 50 per cent of the expenditures in the institution will be devoted directly to faculty instruction, that is, faculty salaries and to activities that are distinctly educational in character. That would include the operation of the library and all of those activities that are set up directly for the education of the students. But certainly the ratio would be quite different from that which has just been given.

DR. GULICK: So then we see that as to finance we have another point at which nursing education differs markedly from the system we use in other types of American education.

I want to ask now what one change in the American system of education of nurses would have the most important effect in helping us to solve this problem of financing of nursing education. What one thing could we do that would have the biggest effect?

Miss Gelinas: One thing we could do to help nursing education would be to place the control of the school of nursing under educational auspices, preferably in the college or university.

Senator Pepper: Mr. Chairman, I thoroughly agree with the suggestion Miss Gelinas has just made that nursing education be taken out of the practical sphere, where it is now, and be put into an appropriate educational institution. Now, I think we will have to see, however, what the consequence of that would be and make provision for it. As has been pointed out and as we have learned in some studies, in many hospitals the value of the services performed by the student nurses exceeds the value of the instruction which they have received. That fact is not true in all hospitals, and there are many in which it would be grossly untrue, but it is applicable in many cases.

While the student may pay for her tuition, loans and board, in whole or in part, it is really the public and the patient who should pay for nursing education if they are to expect high quality public and private nursing care. For, at the present time, the public and the patient are really paying in poor health care for a deterioration in nursing service by reason of increased fees accompanied by a shortage of nurses and a relative decline in enrollments of nursing schools.

I think we will have to come to the time when hospitals will be serving their patients through regular trained graduate nurses and that there will have to be a system worked out by which the patients will be able to pay a fair rate. I mean by that a fair remuneration that will entitle the nurse who renders the nursing service to a decent livelihood. We have got to provide a system that will enable the patients to pay what their nursing care is worth. When we do that, we will add a great deal to the accomplishment that Miss Gelinas has suggested that nursing education be taken out of the hospital and be put into the educational institution.

Dr. Gulick: I wonder what our next task is going to be then when we reach the conclusion that nursing education has reached a point in American history where it cannot be left purely on an apprentice basis, where it has become a problem of preparing properly selected young women and young men for nursing service in educational institutions, directed by educational authorities rather than by service institutions interested in some other function. Now, when we reach those conclusions, then what do we do about it? What is the next thing that we have to do?

Senator Pepper: Well, I think the first thing is to encourage public institutions supported by public funds to install appropriate and approved nursing schools, so they will have nursing schools just as they have other professional schools. In the second place, the public, federal and state, could give assistance to private institutions in the form of grants in aid for the nursing education that they have made possible to provide the facilities in which nursing education might be acquired. But there will always be the problem of assisting the individual to take advantage of that. I think we have to set up a system of scholarships and fellowships which will be generously supported by public funds to allow competent people to enter into nursing training.

In the next place, I think we have got to provide in certain cases, probably, loan assistance; although I prefer the scholarship method rather than the loan method, because we know what it is to be burdened down for many years of your life with a loan. But I think adequate scholarships, adequate fellowships, certainly if they are adequate in amount and if the total amount available is adequate, can do a great deal to solve the problem of the individual student.

Miss Gelinas: I would like to strengthen Senator Pepper's statement a little bit in this way and say that I think that the federal government must set up a system of nationwide scholarships which will provide the well qualified student, who is economically handicapped, with sufficient funds to study in any accredited school of nursing, private or public, so that she may choose the school of her choice and not be restricted by state boundaries.

Miss Sleeper: Mr. Chairman, I would like to say a word as to gifts from private individuals to private schools, private colleges carrying on nursing programs and private funds given for scholarship aid. I think that only as we can interest the citizenry in this whole problem will we be entirely successful. People are far too apt to feel that if the government will do it they then have no individual responsibility. We know now in our nursing organization the value of lay participation, and that lay participation takes various forms. It has been tremendously helpful to us in upgrading our nursing schools and especially in upgrading our nursing services. I think we should not leave out the private citizen.

Dr. Brown: It seems to me that both the suggestions that have been made as to public assistance and private assistance are excellent. In order that we may get that assistance I would like to suggest that the national and the state nursing associations put on a large program of public education.

I look at your profession with a tremendous amount of interest but also with some comprehension of how little society knows about your professional education, about the situation that you face in your relationship to the hospital, about the financial difficulties. You have an enormous story which must be told. It must be told consistently and persistently all over the country if you are going to have the informed lay people who can help you either with private gifts or who can help you in the Congress of the United States.

Miss Gelinas: I think there is another important group that must help us in nursing education. That is the group that owns and operates the hospital. We have one of the finest teaching fields in the world in the hospital, and we must ask these hospitals — medical, surgical, pediatric, obstetric, psychiatric, tuberculosis, cancer hospitals—to help us in this educational program for student nurses. We certainly need their support and help.

Senator Pepper: May I interpolate this lest there be any misunderstanding about the suggestion that public

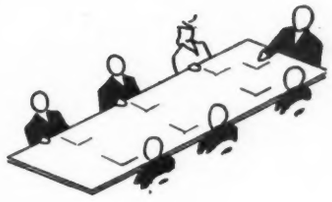
assistance should be given. I think all of us will agree that under our system of government and our theory of society we never think of public funds except to supplement private funds. However, where private funds have not brought about a situation which the public interest requires, then rather than let the situation be to the detriment of the public, public funds would have to be provided.

Today, for example, I understand that we have a shortage of approximately 42,000 nurses. Now, the public has an interest in having—if that is the right number—42,000 more competent nurses to attend the public. We pay policemen to guard us at the street intersections against accidents, and we pay other people who are our public servants. Now, what more desirable class of people to serve the public could be found than those 42,000 additional nurses that we need right now? Surely it would be proper for the Congress to make it possible for the Public Health Service to aid enough students to enter schools of nursing to provide the nurses the public needs at the present time.

MISS SLEEPER: We need graduate nurses. Under the Bolton Act the funds were given to the students for the purpose of furnishing nursing service to the hospitals. We were in a war emergency. Today, to a degree, we are still in an emergency. Perhaps in nursing the emergency is greater. But if we are making any long range plans for nursing education and how to pay the costs of nursing education, we must be sure—and I am sure Senator Pepper included this in his thinking—that we don't give scholarships to the students and then expect them to go into the hospital and earn their education all over again. That can easily happen. Now, if we give scholarships we must give them for nursing education.

CHAIRMAN GULICK: Is it dangerous for nursing education, or any other type of education in America, to receive public support in the form of taxation?

MISS SLEEPER: In nursing we see public support from taxation in two types of schools—one, let us say, the city or the county or the state hospital. Now, actually, that money is



not given to conduct a nursing school. I am quite sure if we could look at the objectives of those who appropriate the tax we would find that that money was given to take care of the patients in those hospitals. Therefore, in the strict sense of the word that is not public support for nursing education. Nursing education is a by product.

We also see money given through tax support to state universities which conduct schools of nursing. There we find that the program is on an educational basis, and the tax support certainly does not seem to be in any way detrimental. It is extremely beneficial. During the war period we saw public monies given to student nurses and some to schools of nursing under the Bolton Act—tremendous sums. I think in spite of all the things that happened to us in schools of nursing during the war period, we owe a great debt to the United States Public Health Service and to Congress which passed the Bolton Act for the upgrading of nursing education that came through the splendid efforts of the United States Public Health Service representatives.

DR. BRUMBAUGH: One of the fundamental issues that has been raised all along in federal legislation appropriating funds for the aid of education has been: What about the control of education? Public policy has vested control of education in the respective states.

If we go to an increased program of federal support of education, does not that very fact pave the way to federal control of education in those areas in which the federal government provides the support, and are we, therefore, going contrary to a long established public policy as far as control of education is concerned? That is a fundamental issue. It is for that reason that I believe that a large part of this support should be given in the forms of scholarships and fellowships to individuals who, in turn, should choose the institutions they wish to attend. Through the payment of adequate tuition and adequate living costs, the budgets of those institutions would be supported without injecting the dual question of state *versus* private control within the state, and of federal *versus* state control.

SENATOR PEPPER: Dr. Brumbaugh is correct in stating that it is the theory of our institutions that the federal government, when it aids in an educational program, for example, or in a hospital program, while it may lay down certain general standards does not usurp the administrative function of the local government or of the state government.

We appreciate that integrity on the part of the local governments in the hospital construction program which we have just enacted. If we will go back in our history, some of the oldest of our state institutions, the land grant colleges, got their origin largely through federal grants of land, yet the federal government never tried to interfere with the curriculums of those institutions or with the personnel of the faculty or administrative staffs, for instance. We have had the Smith-Hughes Act on the statute books of the nation for many years. That is where we give assistance to colleges and schools in giving vocational training. Yet the federal government has never interfered in the actual administration of the institutions which are the recipient of that aid.

When the federal government contributes to the education or the health of the American people it is providing in a very proper way for the strength of the public. So the only thing we need concern ourselves about is that we properly exercise the federal power to assist in furnishing this necessary professional education.

DR. BRUMBAUGH: Mr. Chairman, I feel greatly encouraged by the point of view that Senator Pepper expresses and agree with him perfectly; if only I could have the same confidence that other members with whom he is associated in Congress share his point of view.

SENATOR PEPPER: You remember that congressmen are elected every two years, and senators every six years, and the president every four years, so I think the people will al-

ways be able to impose reasonable safeguards even upon their Congress.

DR. BRUMBAUGH: May I say further that what Senator Pepper has pointed out is decidedly true. I made a study recently of the federal government's participation in support of education, and I found in the last biennial report of the United States Office of Education that the federal government had made direct appropriations for educational purposes, to higher education alone, amounting to $500,000,000, which was half as much as the total budget for higher education in the country.

I can foresee those appropriations growing and expanding, and I think it is absolutely necessary that they should. We must remember that the federal government has imposed on all citizens an income tax which has limited greatly the resources within the states for educational purposes and for other social needs. With the allocation of one of the major sources of income to the federal government, there must go a corresponding responsibility for appropriating some of this income back to the states.

But let me emphasize one thing. I certainly hope that the Senator and all of those who have an interest in this matter will stand pat on the fact that we shall not require the states to match in any way what the federal government provides, because by so doing we defeat the purpose of equalization. The states that have ample funds are able to match appropriations, and the states that don't have the funds are not able to match them. The provision that states must match federal funds defeats the purpose for which an equalization fund is set up.

SENATOR PEPPER: I am glad you emphasized that, Doctor. Especially is that true in the rural areas. As we all know, they are in many sections of the country the worst served and the least able to put up any kind of contribution.

Reconstruction Begins With Personnel

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THE tradition of charity and consideration for those in need has been and still is a predominant characteristic of hospitals. This has resulted in philanthropy in varying amounts to most hospitals. With few exceptions, though, gifts from interested individuals have not been of sufficient proportions to meet the fiancial burdens which hospitals have imposed upon themselves. This is due primarily to the continuance of the worthy tradition of hospitals to care for the sick regardless of the individual's ability to pay.

Inadequate financing created within hospitals a tendency to obtain the services of employes at a substandard level of wages. In this way the hospital employes became the largest donors to hospitals, although they were the least able to make such contributions. Fortunately, this situation was more prevalent in years past than it is today, but there still is much ground to be possessed.

It is unlikely that hospitals will soon be able to compete in salaries with industry inasmuch as the product they sell, namely, service, too often can be paid for in its entirety by only a small cross section of our population. The gap between hospital salaries and those of industry has, however, been steadily decreasing. This is the result of the realization that a hospital should pay an adequate living wage to its workers and, in return, demand quality service from them.

Every hospital administrator is so familiar with the inadequate sense of responsibility of many employes, especially in the domestic group, during the past few years that he should devote much energy to ridding the hospital field of such personnel. There should be no place in the hospital for the untidy chronic alcoholic or the feeble-minded employe. Such individuals injure the good public relations created by the faithful, intelligent, energetic employes. The removal of unqualified personnel from the pay roll can be accomplished only by delving deeply into employe-employer relationship.

The first consideration should be that the employe is entitled to live as a respectable member of the community. This necessitates some change in the concept of low salary plus maintenance. It is easy to rationalize that a room is worth a certain amount a month, but if the employe, either single or married, has a home he has no need for the room which the hospital offers. Furthermore, his own living accommodations most likely are superior to a dormitory or attic room provided by the hospital.

The same is true of meals. It is easy to calculate that 21 meals a week have a certain cash value, but what employe eats 21 meals a week at the hospital? To do so would mean that on half days and days off he must return to the hospital at each meal hour. Obviously, if he is seeking diversion away from his work he will not return at specified hours for his meals. If he is married and has a home, he most certainly will desire to have a considerable portion of his meals with his family. Consequently, he takes a loss in the value in his board, thereby reducing his theoretical income.

Many hospitals are gradually abandoning the low salary plus maintenance remuneration and instead are paying a full cash salary. The employe can then live and take his meals where he likes. Should he wish a room at the hospital one may be rented in the dormitory at a nominal rate. Should he desire to take some meals at the hospital he can go to a cafeteria where he can select food of his liking. The advantages of such a system are many.

The employe can live at home with his parents or, if he is married, live in his own home as a member of the community. He can indulge in more varied interests when off duty. He does not live in the hospital dormitory which, too often, is crowded and poorly furnished. He does not have as his only companions other hospital employes. His discussions when off duty do not center on his work and he does not share the petty grievances of other employes which quickly become greatly exaggerated.

The age old custom of complaining about food is eliminated. These complaints have not always been without foundation, as the menu too often is a fixed one without any choice. If one or more articles on the menu are not to his liking he has the alternative of eating or doing without. It is also true that food prepared in bulk to feed a large number of individuals can be unappealing.

The present high cost of food and rent has created a slight tendency for certain employes to desire maintenance. It is to be hoped that this is only a temporary condition and in the near future those employes will be able to lead a normal home life the same as employes in the business or industrial field.

Let's Abandon Split Shift

The split shift is another tradition of hospitals which should be abandoned. It is particularly marked in the nursing and dietary departments. Its origin developed from the inadequacy of financing hospitals. Nursing and dietary loads of work are greater at certain hours of the day; therefore, to have an adequate number of employes on duty at peak work hours the employes are asked to work only during the hours of greatest work needs, then take a few hours off duty and return to finish their required number of hours on duty for the day when the next peak load of work arrives.

It is difficult to schedule the time of employes on a consecutive eight hour basis, but hospitals are beginning to work out such schedules. It is only fair to the employe to do so; otherwise he will be at the hospital for ten or twelve hours a day as the few hours off duty on a split shift are not sufficient for him to do anything.

To report for duty at 6 or 7 o'clock in the morning, which is the starting hour at many hospitals, and to remain at the hospital until 6 or 7 o'clock in the evening, even with a rest period, creates in the employe a feeling that his work day is too long. Is it any wonder that hospitals in which such conditions exist cannot compete with business and industry?

Another relationship with employes which hospitals are beginning to realize that they have neglected too long embraces such items as vacations, sick leave, periodic salary increases and advancement from one position to another. A definite program covering these phases of employment will do much for employe-employer relationship. The hospital is within its rights in developing such a program not only to be fair to the employe but also, at the same time, to protect itself against malingering and incompetence.

Sick leave should only be given for bona fide illness. Periodic rises and advancement in position should be based on merit. Seniority alone is not justification for advancement. The employe must merit that advancement. If this is made clear to each employe there is a definite stimulus for him to perform his duties in a competent manner so that he will be properly rewarded. If he is incompetent there is no reason for him to expect to advance or even to hold his position.

Overtime pay is another problem for the hospital to solve. The amount of work to be performed in a working day should be reasonable and the department head should expect it to be completed. If the employe purposely drags out the work so that he must stay overtime, his overtime pay is an object of suspicion. If more work is assigned than can reasonably be accomplished in a working day, overtime compensation should be granted willingly in the form of either extra time off duty or a cash consideration.

During the past several years hospitals have been so desperately in need of employes that screening of applicants has become a lost art. Anyone applying for a job who looked and talked as though he could work was employed. Many instances are known of hospitals employing someone in the afternoon, giving him a room in the dormitory, his evening meal and breakfast the next morning and then finding that he had disappeared. All that the alleged employe wanted was a place to sleep and a couple of meals, with no intention of working. The failure to select employes properly has resulted in an amazing turnover in many hospital departments. This is expensive and results in an inferior quality of service.

Proper training of employes in their duties has also been much neglected. Too often a new employe is told briefly what his duties are, assigned to a hospital division, expected to find his way and do his work without supervision. Even a reliable person, anxious to work, will become discouraged under such conditions. Hospital employes, the same as employes in other fields of work, should obtain satisfaction out of good performance. To deprive them of this opportunity is unfair to the employes and costs the hospital both financially and functionally.

Must Pull Out of the Mire

The war is over. Reconstruction days are here. Every administrator is thinking of ways to lift his hospital out of the mire that has engulfed it during the past several years. A good starting place is employe-employer relationship. To accomplish this adequate financing will be required. How to obtain the needed income without overburdening patients is another of the many problems yet to be solved, but if hospitals are to carry on, their boards of managers, the staffs and the administrators must unceasingly labor toward the solution of all existing complexities. It is difficult but not impossible.

In order that I shall not be misunderstood I must confess that my hospital is just beginning the program I have advocated and hopes to have it in effect in the near future. At present many departments are organized in whole or in part along the lines I have outlined. As rapidly as possible the other departments will be so organized. In those departments where adequate pay, good working hours and training for the job have been instituted, a superior type of employe has been obtained, the turnover has been greatly reduced and the quality of service has been much enhanced.

ABOUT PEOPLE

Administrators

William S. McNary, executive director of Colorado Hospital Service, Denver, since its inception in 1938, has accepted the position of executive vice president and general manager of Michigan Hospital Service. Mr. McNary has long been active in both hospital and Blue Cross administration. A graduate of the University of Colorado in business administration, he was business manager of Colorado General Hospital until he joined the Blue Cross. Under his direction the organization has increased its enrollment to 400,000 members. Mr. McNary is also a member of the Blue Cross Commission.

Mrs. Olive Russell, R.N., has been appointed superintendent of Carrie F. Wright Hospital, Newport, N. H. She is a graduate of Hillsboro County Hospital, Manchester, N. H., and served as operating room supervisor in the Corey Hill Hospital, Boston; as night supervisor of Memorial Hospital, Concord, N. H., and as superintendent of Alice Peck Day Hospital, Lebanon, N. H.

Sister Rosa, who is supervisor of all hospitals of the Order of Sisters of Charity, has been promoted to the position of assistant to the Superior of the Order, in which capacity she will continue to supervise the hospitals. Sister Rosa was formerly administrator of Providence Hospital, Washington, D. C.

Dr. Daniel Morse has been selected to head Peoria Municipal Sanatorium, Peoria, Ill., succeeding **Dr. M. Pollak.**

Dr. C. C. Hillman assumed the duties of administrator of James M. Jackson Memorial Hospital, Miami, Fla., on December 15.

The **Rev. Lawrence N. Strunk,** pastor of St. Stephen's Church, Harrisonburg, Va., has been called by the board of directors of St. Lucas Evangelical Deaconess Hospital, Faribault, Minn., to serve as superintendent of the hospital. The Rev. Mr. Strunk has studied at Columbia University in the field of pastoral care and has been preparing himself for the work of hospital administration and chaplaincy.

Sister Mary Therese, who has been engaged in hospital work since 1913, is the new administrator and Superior of Mercy Hospital, Chicago. She succeeds **Sister Mary Timothea,** who resigned because of illness.

Arthur A. Winston, formerly purchasing agent at Shadyside Hospital, Pittsburgh, has accepted the post of administrator at Rochester General Hospital, Rochester, Pa. Another personnel change reported at this hospital is the appointment of **Elizabeth V. Kaufman** as superintendent of nurses. Miss Kaufman returned recently from three years of service with the army in the South Pacific.

W. C. McLin, formerly assistant superintendent of the Jewish Hospital, Cincinnati, has accepted a similar post at Methodist Hospital, Indianapolis.

Oscar Schweidenbach has been appointed director of Lutheran Hospital, Brooklyn, N. Y.

Evalyn F. Bradley, R.N., has been appointed superintendent of Memorial Hospital, North Platte, Neb., which is owned and operated by the Lutheran Hospitals and Homes Society. Miss Bradley, a graduate of Nebraska Methodist Hospital School of Nursing, Omaha, served two years in the army nurse corps. She succeeds **Helen Bokelmann.**

Joseph P. Hart has been appointed assistant director and purchasing agent at Paterson General Hospital, Paterson, N. J. He had formerly been associated with Staten Island Hospital, Staten Island, N. Y., and Overlook Hospital, Summit, N. J.

J. Harold Johnston has resigned as director of Middlesex General Hospital, New Brunswick, N. J., to become executive secretary of the New Jersey Hospital Association, with headquarters at Jersey City.

Charles M. Smith has been appointed assistant director of East Orange General Hospital, East Orange, N. J., it has been announced by **Edgar C. Hayhow,** director. Mr. Hayhow has also announced the selection of **Jennie Baker,** formerly of Jackson Park Hospital, Chicago, as director of nursing at East Orange.

Carl C. Lamley, recently released from the army medical administrative corps with the rank of lieutenant colonel, has been appointed administrator of Highland Park Hospital, Highland Park, Ill. Mr. Lamley studied hospital administration at Northwestern University and made a six months' administrative study at St. Luke's Hospital, Chicago, in conjunction with his work at Northwestern. He served as vice president of the Hospital Club and as chairman of the Hospital Administration Forum.

Cloice M. Lane, former superintendent of Kanabec Hospital, Mora, Minn., is the new superintendent of Hazel Hawkins Memorial Hospital, Hollister, Calif., succeeding **Helen Osten.**

Albert H. Scheidt, administrative director of Michael Reese Hospital, Chicago, has assumed the post of administrator of the new Foundation Hospital of the Alton Ochsner Medical Foundation in New Orleans. Mr. Scheidt had been associate director of Michael Reese Hospital in 1940-41 and resigned to become head of Miami Valley Hospital, Dayton, Ohio. He entered the medical administrative corps of the army in 1942 and rejoined the Reese staff as administrative director a little over a year ago.

Joseph Vance, recently released from the navy after four years of service as a hospital corps officer, has been appointed assistant superintendent of South Highlands Infirmary, Birmingham, Ala. He succeeds **D. O. McClusky Jr.,** who was appointed administrator of Druid City Hospital, Tuscaloosa, Ala.

Isabella Williams, formerly purchasing agent at Michael Reese Hospital, Chicago, and a graduate of the Northwestern University course in hospital administration, has been appointed administrator of Chenango Memorial Hospital, Norwich, Conn.

Mary A. Morris has resigned as superintendent of Miles Memorial Hospital, Demariscotta, Maine.

Dr. Glidden Brooks has accepted the appointment as director of Central Maine General Hospital, Lewiston, Maine. He succeeds **William Brines.**

Cora Pike recently resigned her position as superintendent of Gardiner General Hospital, Gardiner, Maine.

Dr. Harry C. Smith has assumed the post of superintendent of Frisbie Memorial Hospital at Rochester, N. H., suc-

(*Continued on Page* 142.)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Do They Keep on Contributing?

DAVID M. CHURCH

New York City

WHEN the matter of cultivation of possible contributors arises, there is always a question of how far down the line we should go. Should we center our efforts on the large givers? Too often, this question is answered in the affirmative and the small giver gets little attention.

The wisdom of this is questionable. The last edition of the "Yearbook of Philanthropy" estimates, on the basis of income tax returns, that more than 56 per cent of the philanthropy in this country comes from the small giver, the person with an income of less than $5000 a year. If this estimate is anywhere near accurate, then certainly the small giver deserves great attention.

What Becomes of the Money?

Yet in most cases his interest is not generally cultivated. He is not kept well informed as to what his money accomplishes. In many instances, he hardly gets a decent "thank you." I can't prove this, but to back up my opinion I have done a little bit of very unscientific inquiry. I approached a friend of mine, whom I know to be a meticulous keeper of personal records, and asked him whether he kept any record of his contributions for philanthropy. He said he did.

I asked him whether he had any idea that his gifts were generally well received and if he had a general impression that his money was serving a useful purpose. His answer was pretty indefinite, but he agreed to go over his list of contributions to check what happened after he gave his gifts.

This man belongs economically in the middle class, and I presume his experience as a member of the contributing public might be fairly indicative of the average. Here is the letter he wrote me after he went over the records of his various contributions:

"My first gift was to a national campaign. They gave me a nice button to wear in my lapel and a sticker to put in my window. I haven't heard from them since.

"My second gift was also to a national campaign. They also gave me a badge and a sticker. I haven't heard from them since, either, but I expect to, for I see by the paper they are about to launch another campaign.

"My third gift was to a group of welfare agencies and was made through solicitation in my office. I have a vague recollection that some time after the gift was made a poster was placed in our office which said 'Thank You,' but I have no idea what my money really accomplished. It was nice of them to say thank you, however.

"My fourth gift was to a welfare society. These people must like me. They send me a weekly bulletin on their work, except during the summer months. Some of these bulletins are routine, but most of them I enjoy reading. They also send me their annual report, and about once a year I get a letter—processed, to be sure, but very human in its content—from the president. Somehow or other, I feel more or less as though they had taken me into their family.

"My fifth gift was to a church out of town—my wife's church, which we never attend. Nevertheless, once a month we get a copy of the *Church Bulletin* with a digest of one of the rector's sermons. I like his sermons and I like his church.

"My sixth gift was to a health organization. They send me their annual report. It always has an attractive cover and is beautifully printed, but the contents seem to be largely accountants' certifications of their finances. I have no mind for figures and this annual report gets to my wastebasket pretty quickly. I am without knowledge as to exactly what this agency accomplishes, but I do think it is extravagant with my money in producing its annual report.

Not So Good for His Soul

"My seventh gift was to a church in my own neighborhood, which I attend too rarely to be considered a parishioner. However, once a year a neighbor calls and asks me for a contribution, which I make. That ends it all for a full year, which is probably not too good for my soul.

"My eighth gift—or gifts, I should say—was to a hospital which in the past has served our family well. About every three months I get a timid little appeal and within forty-eight hours after I send my check I get a very genteel letter of thanks. I sort of like them because of their timidity and gentility.

"My ninth gift was to a sectarian organization combining a number of social work agencies. This appeal always comes to me from a close business associate. I have no affiliation with the denomination concerned, but I give. I always get a prompt letter of thanks and that ends it all for a year. I sometimes think my motive in giving here is in response to a gentle sort of blackmail.

"My tenth gift was to a youth or-

Condensed from a chapter in the Yearbook of Philanthropy, edited by John Price Jones. New York: The Inter-River Press, 1946.

PENICILLIN-C.S.C.

Crystalline

SODIUM SALT

IS PENICILLIN G

AND REQUIRES NO REFRIGERATION

"NONE BETTER THAN PENICILLIN G IS NOW AVAILABLE"*

* Council on Pharmacy and Chemistry: Penicillin Facts and Rumors, J.A.M.A. 131:1423 (Aug. 24) 1946.

Presenting penicillin G—clinically the most effective penicillin species available—Crystalline Penicillin-C.S.C. Sodium Salt can be depended upon to produce optimal therapeutic effects. It induces highly satisfactory penicillin blood levels and maintains them for 2 to 3 hours.

- ***Highly Purified***—Contains not less than 1,500 units per mg., virtually eliminating untoward reactions attributable to impurities.
- ***No Refrigeration Required***—Crystalline Penicillin-C.S.C. Sodium Salt can be kept at room temperature—even in the tropics—and does not require refrigeration.* It may be carried in the physician's bag or stored on the pharmacy shelf without potency loss.
- ***Well Tolerated Subcutaneously***—Can be administered subcutaneously—even in large doses—with virtually no pain or local reaction.
- ***Potency Clearly Stated on Label***—The physician knows at a glance the degree of purification of the penicillin administered.

Crystalline Penicillin-C.S.C. Sodium Salt is available in serum-type vials containing 100,000, 200,000 or 500,000 units.

* CAUTION: Once in solution, however, all penicillin requires refrigeration.

ACCEPTED AMERICAN MEDICAL ASSN.

Crystalline Penicillin-C.S.C. Sodium Salt is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

C. S. C. PHARMACEUTICALS
A DIVISION OF
COMMERCIAL SOLVENTS CORPORATION
Terre Haute CSC Indiana, U.S.A.

ganization in my own neighborhood. Once a month they send me a mimeographed bulletin. It is badly written and it is badly produced, but, bless their hearts, they are trying and they have my affection.

"Finally, I find I give each year to several other smaller organizations —small amounts, to be sure—and I have no recollection of receiving anything from any of these except appeal letters. There are nine of these organizations which take my money and then ignore me.

Only Four Do a Real Job

"To recapitulate, it seems I make 19 contributions a year. Twelve of these organizations appear to want only my money and care little about my interest. Three seem to make a feeble attempt to hold my friendship and interest. Only four do a real job to hold my support and make me proud to be among their givers.

"This is all very disillusioning to me. It causes me to wonder why I give. I am afraid I give out of sheer habit to some and to others, because the right people ask me to give. You have made me think. I am going to change my giving habits."

Of course, this is fairly flimsy evidence on which to base a charge that there is too little cultivation of the small contributor today. However, I believe this is true: When the money is in, the contributor is forgotten until a short time before he is to be approached again for a gift.

We hear a great deal today about changed economic conditions. The day of the big philanthropist is gone, we are told; if the necessary money to maintain our philanthropic agencies is to be raised, there must be a broadening of the base of giving. But certainly you are not going to broaden the base of giving unless you intensify your efforts to create deeper interest on the part of the contributors who now constitute your public. There is still a job to be done in that direction.

During recent years, there has been a constantly increasing endeavor to enlist the support of organized labor and employe groups for social welfare work. The effort has been highly successful. The employed groups, both organized and unorganized, are now giving generously to such work. But I suspect they are not entirely happy about their giving. A recent editorial in a nationally distributed magazine of one of the great labor organizations says in part:

"Too many welfare agencies are satisfied and smug and holier-than-thou. They tell us we have a responsibility to them—to give and to help —but they seem to have no responsibility to us. They tell us that voluntary taxation for social services is a sign of good citizenship, but when we ask for representation along with taxation, as a sign of democratic faith, they dust off their antiquated laws at us. They mellow during campaign time. . . . It is a one way street—dead end."

Even though it shows some spleen, that statement can be regarded as a storm warning.

There are also some evidences of self criticism within the field of social welfare work itself. For example, Charles Dilday of the Chicago Community Fund made this statement:

"The neglect of proper agency public relations results primarily from our tendency to live within ourselves. We do not go beyond our own staff and board members in identifying our programs and the fields they cover. We have not told why we do what we do in the way we do it in simple, understandable, everyday terms. We have not shared our philosophies and the processes for their accomplishments with those from whom we seek support."

Perhaps those two statements are not fully representative of general thinking, but it may be that they are. It may be that you are going to be faced with constantly increasing demands from your contributors for an accounting of your stewardship, and if you do not give a satisfactory accounting you will face growing difficulties in raising the funds required to carry on your work.

VOLUNTEER ACTIVITIES

They Know How to Make Money

The famous fashion show put on annually by the woman's board of St. Luke's Hospital, Chicago, last year showed a profit of $38,000, the highest net in its nineteen year history. The shop, another project of the board, made $5500 and all together the woman's group contributed $45,358.75 to the hospital for free care and for the development of projects which it sponsors. It takes keen organizing ability as well as tireless work to raise that much money.

"As Well as Could Be Expected"

So far as is known, the only hospital telephone service volunteers are those at Mountainside Hospital, Montclair, N. J. They answer telephone inquiries from relatives and friends in regard to patients' conditions, releasing the nursing staff for nursing duties. Mrs. E. W. Congdon Jr. is chairman of the Telephone Service Corps.

Smarter Display

Gone is the secondhand shelving. In its place are new display shelves of plate glass with chrome fittings and bleached white oak frames, mirror backed. When the job is done, the board of the gift shop at Presbyterian Hospital, Pittsburgh, plans to have a formal opening for the shop's many patrons. In the meantime, it is "business as usual."

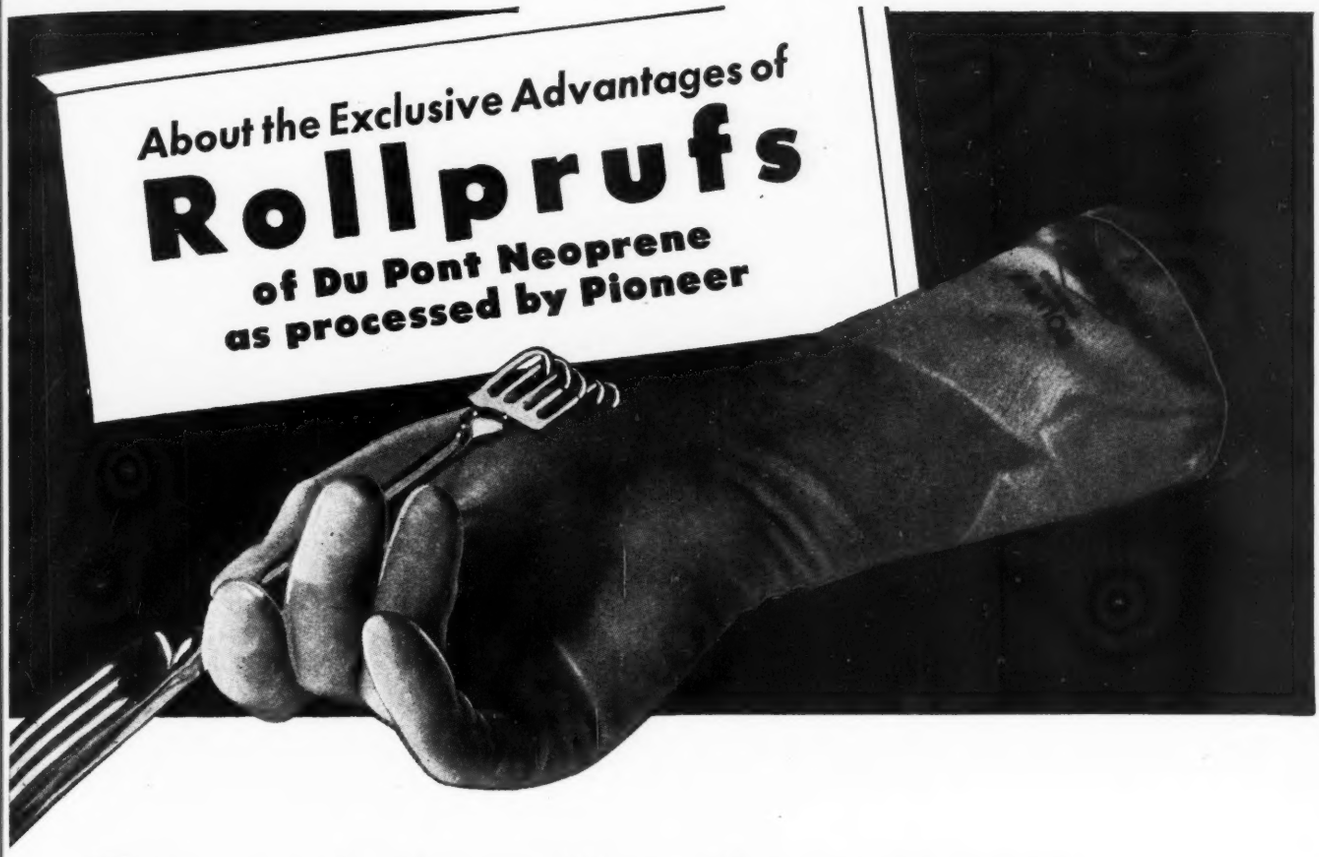
Snagged Hose and Tempers

The feud between dining room chairs and nylon hosiery goes on in most of the employes' dining rooms of the nation. The hospital carpenter smooths off the rough edges of the chairs, the chairs are bumped against the table and each other for a few days or weeks and—more snags on hose and tempers.

The gals at Grant Hospital, Chicago, are offering a prize for the best suggestion for a bumper arrangement to prevent the chairs from roughing. The prize, naturally, is a pair of nylons.

It looks as if the ever faithful women's auxiliaries of the country would have to put in an order for metal dining room chairs as a contribution to employe morale.

Grant's women's auxiliary did not feel too downcast when it slipped back a notch in its rummage sale receipts in the autumn. Nor should it when the fact is that $2300 was cleared, an amount exceeded only in 1944.



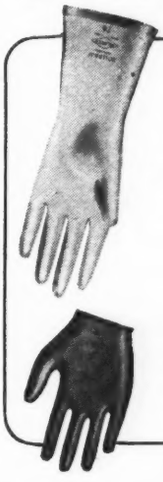
These gloves offer the surgeon unusual finger-tip sensitivity

MANY doctors have reported their discovery that Rollpruf Surgical Gloves of neoprene give them notably greater finger-tip sensitivity than gloves of natural rubber. The Pioneer processed neoprene, soft of texture and tissue-sheer, apparently has unique ability to transmit "feel" to the surgeon's fingers — but without sacrifice of the durability and protection expected of a surgical glove.

This is so important a quality that every surgeon will want to check it for himself.

In trying neoprene Rollprufs you find they give you also unusual finger freedom, are less cramping to the hands, fit snugly without wrinkles and because of the flat-banded cuffs, will not roll down to annoy during operations. Also they are apparently free of the natural rubber allergen which causes dermatitis.

These advantages are highly desirable, if true. It pays to prove them for yourself, as many hundreds of hospitals have done. Order some from your supplier — or write us if he doesn't have them. *The Pioneer Rubber Company, 240 Tiffin Road, Willard, Ohio, Los Angeles.*



Rollprufs of Latex

First quality natural rubber, sheer, flat-banded cuffs, cost no more than quality rolled-wrist gloves.

Quixams of Neoprene

Either-hand short wrist examination glove, now made of finest quality neoprene. Any two is a pair — less cost.

A Discovery About Neoprene

Neoprene must not be confused with synthetics used in tires. Pioneer's 9 years of experience with it prove its extraordinary advantages in a surgical glove. Besides, neoprene stands contact with oils, petrolatum or acids that damage rubber.

PIONEER *Surgical Gloves*

The Result of Over 25 Years of Quality Glove Making

A Formulary Is Essential

to Efficiency in the Pharmacy

W. ARTHUR PURDUM
Chief Pharmacist
Johns Hopkins Hospital
Baltimore

THE primary function of the hospital pharmacy is to furnish efficacious drugs and pharmaceuticals and related medical supplies to both inpatients and outpatients. If this is to be done promptly and economically a formulary is essential.

Before a formulary can become a reality, it is necessary that a formulary committee be appointed by the director. This committee, in different institutions, is variously called the pharmacy committee or the therapeutics committee. Membership should be comprised of representatives of the principal medical services and the hospital pharmacist. The pharmacist should serve as the committee's secretary and keep minutes of all transactions.

Pharmacist Should Be Consulted

It is advisable for the director, before making appointments, to consult the pharmacist inasmuch as the latter will often know better than the director which medical men will be cooperative and will function actively on the committee. Furthermore, it is recommended that appointments be made for one year only. In this way, dead wood can be removed and replaced with active material.

The next step is for the committee to extend an invitation to all services of the hospital to submit a list of drugs, including strengths and dosage forms, desired for use in these respective departments.

While awaiting submission of these lists, the committee should proceed to formulate its policies regarding scope and bases for admission of drugs. Eight rules controlling admissions were adopted by the New York Hospital some years ago. These have worked out satisfactorily and have been adopted, with modifications, by other institutions. The rules are as follows:

1. Simple official (pharmacopoeial) substances will be admitted, when requested, unless they have become superfluous.
2. No article will be admitted, except for controlled research, before its therapeutic value has been established.
3. No article of secret composition will be admitted.
4. No article that is sold under a proprietary name will be admitted under such a name if a substance of identical composition can be obtained under a nonproprietary name.
5. No mixture of two or more active substances will be admitted unless evidence is submitted that the mixture presents therapeutic advantages over the simple substances.
6. No proprietary article will be accepted before it has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in "New and Nonofficial Remedies."
7. Requests for articles which are not included in the formulary of the hospital but which are desired for use in controlled research that has been approved by the head of the department in which the investigation is to be conducted will receive consideration by the committee.
8. It is the policy of the committee to discourage the intravenous and intramuscular injection of substances that should be administered orally.

In the 1937 report of the committee on pharmacy of the American Hospital Association, it is cited that digitalis in ampule form, if used routinely in a 300 bed hospital, would cost annually from $12,840 to $15,140 more than the same amount of digitalis in the form of pills. Actually, there are few instances in which there is need for intramuscular or intravenous digitalis.

Eliminates Superfluous Items

After receipt of the requested drug lists, the committee proceeds to select the best representatives in each class and to eliminate those which are regarded as undesirable or superfluous. After completion of this task, the actual preparation of the formulary is turned over to the pharmacist, the committee then serving in an advisory capacity. In the meantime, the various services of the hospital are notified regarding substitutions in and deletions from their lists of recommendations. This gives these departments the opportunity to come back to the formulary committee with suggestions if they are dissatisfied with the action taken by the committee.

Because, frequently, new drugs are made available which render older therapeutic agents less valuable or obsolete, provision must be made for frequent revision of the formulary. Revisions should be made at least as often as new editions of the official compendia appear. Between complete revisions of the work it will be necessary to issue addenda.

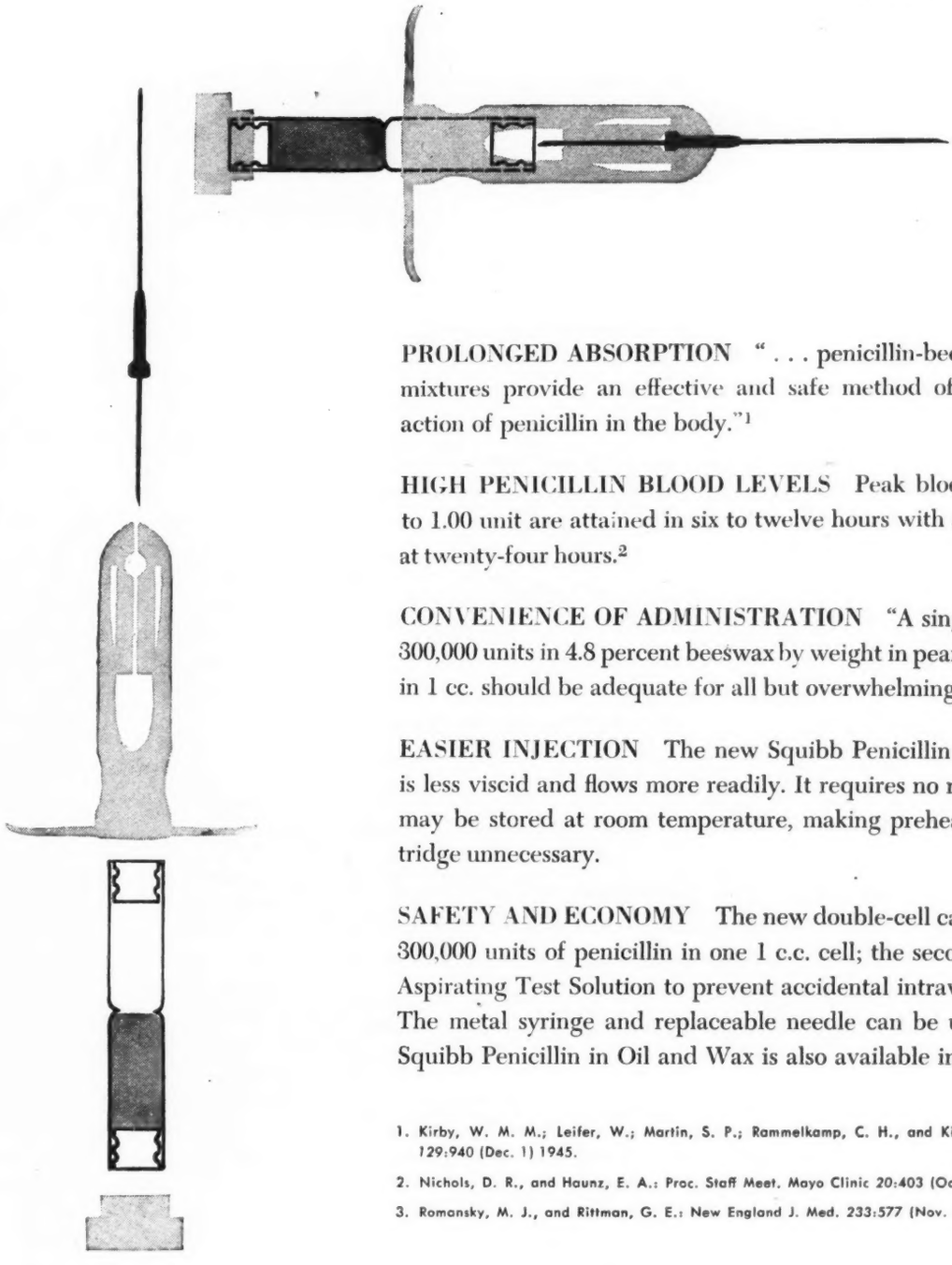
The hospital formulary in its simplest form is nothing more than a collection of nonofficial formulas

Presented at the American Hospital Association convention, 1946.

FOR PROLONGED ACTION—EASIER ADMINISTRATION

SQUIBB *Penicillin*

IN OIL AND WAX



PROLONGED ABSORPTION "... penicillin-beeswax-peanut oil mixtures provide an effective and safe method of prolonging the action of penicillin in the body."[1]

HIGH PENICILLIN BLOOD LEVELS Peak blood levels of 0.06 to 1.00 unit are attained in six to twelve hours with at least 0.03 unit at twenty-four hours.[2]

CONVENIENCE OF ADMINISTRATION "A single daily dose of 300,000 units in 4.8 percent beeswax by weight in peanut oil contained in 1 cc. should be adequate for all but overwhelming infections."[3]

EASIER INJECTION The new Squibb Penicillin in Oil and Wax is less viscid and flows more readily. It requires no refrigeration and may be stored at room temperature, making preheating of the cartridge unnecessary.

SAFETY AND ECONOMY The new double-cell cartridge contains 300,000 units of penicillin in one 1 c.c. cell; the second cell contains Aspirating Test Solution to prevent accidental intravenous injection. The metal syringe and replaceable needle can be used repeatedly. Squibb Penicillin in Oil and Wax is also available in 10 cc. vials.

1. Kirby, W. M. M.; Leifer, W.; Martin, S. P.; Rammelkamp, C. H., and Kinsman, J. M.: J.A.M.A. 129:940 (Dec. 1) 1945.
2. Nichols, D. R., and Haunz, E. A.: Proc. Staff Meet. Mayo Clinic 20:403 (Oct. 31) 1945.
3. Romansky, M. J., and Rittman, G. E.: New England J. Med. 233:577 (Nov. 15) 1945.

SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

in common use in the hospital. This type of formulary is usually published in the form of a booklet of vest pocket size. It serves a useful purpose in the hospital but quite naturally its usefulness is limited.

The trend today is definitely away from a collection of formulas *per se*. Modern hospital formularies, in addition to providing hospital formulas, also give information regarding all drugs and preparations accepted by the formulary committee and contain much other useful reference material for the doctor, nurse and pharmacist. Some of these appear in bound form and others are loose-leaf books, each form having advantages over the other. The bound book is more convenient to handle, there being no danger of losing loose pages. On the other hand, the loose-leaf book is more easily kept up to date by adding new pages as they are needed.

Things to Be Included

What should be the content of the combined formulary and handbook? In addition to monographs on all therapeutic and diagnostic agents in use in the hospital, information on the following should be helpful to the inexperienced physician and nurse:

1. Tables of weights and measures.
2. Conversion tables.
3. Fundamentals of prescription writing.
4. Prescription container sizes available in pharmacy.
5. Pharmaceutical vehicles.
6. Pharmaceutical coloring agents.
7. Table of commonly used Latin terms, their abbreviations and translations.
8. Digest of laws affecting the physician, pharmacist and nurse.
9. Treatment of acute poisoning by common poisons.
10. Treatment of other common emergencies.
11. Regulations to provide safeguards against anesthesia explosions.
12. Formularies in general use in the United States.
13. Table of physiological data.
14. Special technics in use in the hospital.
15. Policy governing admission of drugs and preparations to the formulary.
16. Policy governing dispensing of formulary and nonformulary drugs to inpatients and outpatients.

While simple formularies give only actual formulas of preparations developed in the hospital, the modern expanded formulary and handbook should give other pertinent information on these products and on all other accepted drugs. The following covers perhaps the minimum for individual drug monographs.

Titles. The English name of the drug or preparation should be given precedence over the Latin title and synonyms. This is in conformity with the policy adopted by the United States Pharmacopoeial Revision Committee and the Committee on National Formulary.

Formula. For a compounded preparation, a formula containing quantities present in one average dose is more convenient to the prescriber than is a manufacturing formula as used by the pharmacist.

For a chemical, the chemical formula and molecular weight should appear. Structural formulas of organic compounds are recommended because they provide the reader with an insight into the relationship between chemical structure and physiologic activity.

Description. A short description of the physical characteristics of the product.

Action. A brief statement of pharmacologic action.

Uses.

Contraindications.

Dosage. The usual adult dose range in metric quantities. If the drug is given by more than one route of administration, the dosage for each avenue of administration should appear.

Forms Available. Dosage forms of the drug available in the pharmacy together with their strengths and sizes.

A purely alphabetical grouping of monographs as is now found in current editions of the U.S.P. and N.F. is not desirable because too much page thumbing is necessary to locate a drug and its several preparations. For example, the monograph for Digitalis begins on page 150 of the U.S.P. XII, Capsulae Digitalis, on page 106, Injectio Digitalis, on page 228, Tabellae Digitalis, on page 465 and Tinctura Digitalis, on page 509. The arrangement to be employed in the U.S.P. XIII and N.F. VIII, that is, drugs and chemicals to be listed alphabetically and followed immediately by their preparations, is better than the present form but is still not suitable for a hospital formulary.

The physician, when referring to the formulary, will be thinking in terms of the disease to be treated or part of the body affected. He will expect to find in one place in the book a list of drugs and/or preparations to choose from. Therefore, the classification of choice would be pharmacologic. With this arrangement, for example, he will find under a section entitled "Circulatory System" or "Cardiovascular Drugs" the available forms of digitalis, digitoxin, quinidine and other cardiac drugs.

Patient Benefits From Formulary

The advantages of the formulary are many. Of first concern is the patient. He will benefit through formulary standardization by receiving quality medication promptly from articles carried in stock by the pharmacy. While it is no secret that the pharmacy attempts to show a profit, at least on paper, standardization on drugs will result in an appreciable saving to the patient.

No formulary or the lack of adherence to a formulary, if one exists, frequently results in delay because articles prescribed are not carried in stock and must be obtained from outside. Further, if the medical staff is permitted free rein in prescribing, often the patient will receive a proprietary specialty, the virtues of which have been extolled by the manufacturer's representative, which is inferior to a standard formulary item accepted by a capable and unbiased committee.

The physician will benefit by having at his disposal a wide selection of carefully chosen therapeutic agents. We all know that many medical schools devote insufficient attention to the subject of prescription writing, which means that the young physician must learn this important part of his profession during internship. Without a good formulary and handbook as a guide, he will be easy prey for the horde of detail men who will descend upon him with the idea of promoting their respective specialties.

The stocking of literally thousands of specialties by the hospital pharmacy can be avoided by the careful preparation of an adequate formulary. Frequent reference to the

formulary by the physician saves valuable time in telephoning or visiting the pharmacy to determine what is available.

The nurse, and particularly the student nurse, will find the formulary a useful source of information. In many institutions the hospital formulary has proved to be a useful adjunct in the teaching of materia medica to student nurses. The formulary can save nursing time, and extravagance of nursing time these days is inexcusable.

Saves Nursing Time

It has been shown that the replacement of hypodermic tablets of codeine sulfate with 1 liter of sterile codeine phosphate solution, 65 mg. per cc., and costing only $19.20 to prepare, saves one week of nurses' time. Similar savings can be effected with other solutions in place of tablets, notably morphine.

The hospital formulary is vital to the economy of the pharmacy. We are all familiar with the myriad barbiturate preparations available. Should we be required to carry all of these in our stocks, hundreds of dollars of hospital funds would be lying on our shelves, whereas the selection of a few outstanding representatives of this large class of hypnotics would suffice. If the pharmacy selects only a few of these drugs, each having a different duration of action, they can be purchased in large quantities at substantial savings. By so doing, inventory will be reduced and dead stock will not be a problem.

We are concerned not only with economy of dollars but also with economy of space—space on the shelves of the pharmacy and space in the medicine cupboards on the wards. In addition to barbituric acid derivatives, other outstanding offenders on our shelves include many vitamin preparations and hormone products.

Formulary standardization paves the way for economical manufacturing in the hospital pharmacy. Numerous preparations made in relatively small quantities can be eliminated in favor of a few products that can be prepared in large batches, thereby effecting a considerable saving of time on the part of the pharmacist. Tremendous savings are possible through the manufacture of sterile solutions in rubber-capped vials.

On the debit side of the ledger looms the danger of too much restriction by an overzealous formulary committee, a committee more interested in economy than in the welfare of the patient. However, this can be avoided through judicious appointments by the hospital's director. A practice to be condemned is the numbering of formulary preparations. The good intention here is to save the prescriber's time in that prescriptions can be written by number; the danger lies in a faulty memory or an illegible hand.

In conclusion, it may be seen that the assets derived from a good formulary far outweigh the remotely possible liabilities, and rational standardization results in marked economy for the hospital without undue restriction on the physician and without deprivation to the patient.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

New Developments in RODENTICIDES

UNDER the sponsorship of the U.S. Fish and Wildlife Service, the Office of Scientific Research and Development and the armed forces, great advances have been made in the killing and poisoning of rats. Their combined findings were of sufficient military and medical importance so that until quite recently these data were classified as confidential.

Medical Importance: In one way or another rats act as vectors of numerous diseases. Their fleas may carry either epidemic or endemic typhus fever. In 1900 in India 10,000,000 persons died of plague (black death) because the rat's fleas were infected with Bacillus pestis. Sewer workers may become ill with infectious jaundice (Weil's Disease) if they come in contact with the urine

Oral Toxic Doses of Rodenticides (Wild Norway Rat)

DRUG	LD50 MGM./ KGM.	BAIT LEVEL	CAUSE OF DEATH	COMMENTS
Sodium Fluoroacetate (1080)	5.0	0.5%	Cardiac depressant and convulsant	Tasteless and odorless, useful against insects
Alpha Naphthyl Thiourea (ANTU)	6.5	0.5%	Pulmonary edema	Mild emetic, mild taste, and odorless
Thallium Sulfate	16	2%	Respiratory failure	Worker should wear rubber gloves
Strychnine	25	1%	Convulsant	Kills mice but too bitter for rats
Zinc Phosphide	40	2%	Fatty degeneration—liver	Stabilizes with calcium carbonate
Arsenic Trioxide	140	3%	Enteritis and neuritis	Rats learn to avoid bait
Best Red Squill		10%		Extremely variable potency
Females	150		Cardiac death	
Males	300			
Poor Red Squill	500+			
Barium Carbonate	1500	20%	Cardiac	Emetic in all but rodents

of infected rats. The bite of the rat may transmit rat-bite fever. Infected rats and other rodents may be the source of tularemia and, finally, the rat acts indirectly in the spread of trichinosis.

In most cities the rat population equals or exceeds the human population. Ninety per cent of these are Norway rats (*Rattus norwegicus*), also called brown, gray, sewer or house rats. These rats are the most carnivorous and aggressive and rapidly decimate their nearest competitors, the black and Alexandrine rats. The Norway rat lives in burrows, grows to more than a pound in size, has four or five litters a year numbering from 5 to 25 rats, is aggressive when cornered and will bite sleeping persons, usually infants and drunkards.

In 1943 "plague rats" were discovered by the ever watchful New York Board of Health workers aboard the tramp freighter *Wyoming* from Casablanca. Fortunately, all of the rats apparently were exterminated and an epidemic did not develop. If bacteriologic warfare is ever attempted against the United States, the rat population will probably achieve the status of public enemy No. 1.

Methods of Extermination: Ratproofing of buildings is highly important, but ratproofing is impossible when rats burrow under sidewalks and in parks as they do in our cities. Gassing with hydrogen cyanide or carbon monoxide is effective when this measure can be done safely. Calcium cyanide, when placed in a moist burrow, provides an easy source of cyanide gas. Automobile exhaust will provide adequately lethal levels of carbon monoxide. Traps of the breakback type may be effective against young rats but the 3 and 4 year old rat will have learned to bat the trap with his paws until the trap snaps and the bait is safely available. A glue board placed along runways is sometimes used by professional exterminators, and an electronic trap may soon become generally available.

Poisons: At the beginning of the recent war Richter of Johns Hopkins University used phenyl thiourea in an attempt to determine the range of bitter taste seen in the rat as had been previously done for man. The investigators were surprised the next day to find all of their rats fatally poisoned! Further study showed that alpha naphthyl thiourea was the most specific poison of the series and disclosed that the rodents died of pulmonary edema, while more highly developed species, such as the cat, dog and man, were relatively much more resistant to this pharmacological effect.

Toxicity of ANTU

The specificity of toxicity of alpha naphthyl thiourea (ANTU) for the Norwary rat is indicated by the following oral LD50's (the dose which will kill 50 per cent of the injected animals): adult Norway rat, 6.5; dog, 12; Alexandrine rat, 25; albino mouse, 75; rabbit, 400; guinea pig, 400, and monkey and chicken (LD 100) 5000 mgm./kgm. As has been previously found with drugs that produce methemoglobinemia, the herbivores are in general more resistant to this new poison than are the carnivores.

Yet another rat poison now available to professional exterminators is sodium fluoroacetate (1080) which was discovered by the Chemical

Warfare Service. 1080 is not nearly so specific in species toxicity as is shown by the following oral LD50's (mgm./kgm.): wild black rats, 0.1; dogs, 0.35 (convulsant poison); cats, 0.35; meadow mice, 0.5; goat, 0.7; horse, 1.0; white rats, 2.5; Norway rats, 5.0; deer mice, 5.0, and leghorn hens. 10.0. Thus, 1080 is an all-purpose lethal agent and can be used as a 0.5 per cent solution in drinking water against all rodents and even ants.

The table on page 94 summarizes our present knowledge on rodenticides and indicates that these two new poisons are much more toxic than are any of the older poisons used for this purpose. Red squill, which was in short supply during the war, is particularly disappointing because of its variability of potency. In contrast to birds, the rat is color blind so that unnatural green aniline dyes may be used in the baits to protect the bird.

ANTU acts as an emetic in many animals, and tartar emetic can be used with 1080 to protect domestic animals other than rodents. All animals rapidly develop a tolerance to sublethal doses of ANTU which begins within three hours and lasts thirty days. For maximum kills, prebaiting with unpoisoned baits is hence desirable. The extreme toxicity of these agents limits their use to the qualified professional exterminator.

Pharmacology: Young rats are from five to seven times more resistant to ANTU. Both rodenticides are sufficiently toxic to be used as a dusting powder (20 per cent level) and the rats are killed by the poison licked from their feet. In the dog ANTU will produce an eightyfold increase in the pulmonary lymph flow and adrenal cortical extract is partially antidotal. ANTU in doses of 10 mgm./kgm. given intraperitoneally to the rat produces depletion of liver glycogen and a rise in blood sugar and prevents glycogenesis.

Prevents Growth of Hair

One gram/kgm. of cysteine hydrochloride antidotes the lethality of 10 mgm./kgm. of ANTU. When administered chronically ANTU prevents hair growth and normal pigmentation and has the characteristic effect of the thioureas on the thyroid gland. The cat develops jaundice as a result of intrahepatic obstruction. The dog made tolerant to ANTU develops a sixfold rise in serum cholesterol. Pretreatment of rats with increased dietary iodine or iodides increases the LD50 from 6.5 to 46 mgm./kgm.

A tentative outline of the treatment for human poisoning with ANTU would consist of gavage, oxygen therapy with pressure breathing and avoidance of fluids, particularly alkaline fluids. The adminstration of BAL or cysteine hydrochloride might also be of value. In studies with tissue slices and breis, sodium fluoracetate inhibits specifically the oxidative metabolism of pyruvic and acetic acids probably by inhibition of dehydrogenation via the citric acid cycle.

The only suggested antidote for 1080 poisoning is the intracardiac injection of procaine hydrochloride to prevent ventricular fibrillation and the symptomatic administration of barbiturates to control convulsions. Neither of these procedures has been very effective experimentally.—C. C. Pfeiffer, M.D.

Periodic Acne!

The ovaries appear to have a definite but variable influence on the condition of the skin. The effect is upon the sebaceous glands, primarily, and a disturbance in this ovariandermal relationship seems to be responsible for the quite common "periodic acne". The skin eruption comes and goes with the menstrual cycle. Periodic headaches may be associated with the condition.

Ovarian Concentrate Armour has been found to be quite beneficial in this syndrome. This preparation is a special sterol fraction, free from demonstrable estrogenic properties, derived from the fat and lipoid fraction of whole ovaries by a special process originated in the Armour Laboratories. It is put up in sealed gelatin capsules (glanules). The recommended dose for periodic acne is one glanule t. i. d. for one month. After this, one glanule t. i. d. for seven to ten days premenstrually may suffice. They should be taken with meals.

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Ovarian Concentrate Glanules

Have confidence in the preparation you prescribe — specify **"ARMOUR"**

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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Frozen Food Industry, Please Note—

Dietitians Have Suggestions to Offer

DEWEY H. PALMER

THE consumption of frozen food, particularly vegetables and fruits, has increased until today it represents a substantial part of the hospital diet. Hospitals are realizing more and more the importance of serving high quality, well prepared food to both their patients and the members of their staffs.

In years past, emphasis on the palatability and attractiveness of food has been lacking in hospital food service. There seems to have been a general assumption that when one was confined to a hospital he must of necessity accept a diet which was not only limited in quantity but all too frequently poorly prepared, unattractive and unpalatable. This attitude toward food served in hospitals has been changing for several years, until now many hospitals have established reputations for serving high quality, attractive, tasty food.

Saves Time and Labor

Hospital dietitians have turned to frozen food not only to increase the attractiveness and palatability of the food served but to decrease the labor required in its preparation. The labor shortage during the war greatly accelerated the use of frozen food. Whether its use will continue to increase will depend largely upon the quality of the frozen food offered in the future and the comparative prices of and competition offered by other types of processed food.

Although accurate figures are not available, I would estimate that in a 200 to 400 bed hospital, located in an area in which frozen food is available in substantial quantities, of the total vegetables purchased, 25 per cent are frozen and of the total fruits purchased, about 50 per cent are frozen. Numerous institutions are now using frozen peas, lima beans and spinach exclusively, and only frozen fruits—peaches, strawberries, cherries and blueberries—are used in pies and cakes.

Unfortunately, the experience of many institutional buyers and dietitians in purchasing and using frozen food has been limited to the war years. While it is true that some institutions would have purchased more frozen food if they could have obtained it, they have at the same time been dissatisfied with many of the frozen products delivered to them. This has been due primarily, of course, to the fact that food shortages characterized the wartime period and, too often, food has been frozen which would not have been considered suitable in times when supplies were plentiful.

Another factor contributing to the low quality of much of the frozen food has been the multiplication of frozen food processors throughout the country. Proper technics and methods have not been widely known or used; the best varieties of fruits and vegetables for freezing have not been developed or have not been available for freezing. Because it was realized that virtually any food that was frozen could be sold, all too often almost anything has.

Despite the initial work done by the Department of Agriculture on the establishment of grades for some 16 varieties of frozen fruits and vegetables, these grades have not been adopted by the industry and little or nothing is known about them by the food buyer or the dietitian.

Frequently, I have heard the dietitian state that she bought "only the best," not realizing that, in many cases, the best was not available and she was frequently paying Grade A prices for Grade B and C quality. In many instances, too, efforts to purchase "only the best" have resulted in hospitals' limiting their buying to one or two widely known brands. To an extent, such a buying procedure has been justified but it is uneconomical and does not necessarily assure good quality at the most reasonable price.

Let me briefly outline some of the comments about specific types of frozen foods that have been made by hospital dietitians.

Some Is Inferior

More criticism has been leveled at frozen spinach than at any other item. Many food buyers would like to limit their purchase to frozen spinach in order to avoid the work involved in cleaning the fresh product. Too often, however, the frozen product is of inferior quality and contains sand, sticks and other debris. It also lacks the appearance and flavor of well prepared spinach.

Although many institutions are purchasing frozen lima beans to the total exclusion of the fresh variety, they are far from satisfied with the frozen product. They complain of lack of uniformity and variation in sizes and in states of maturity.

Peas are the most widely used frozen vegetable but, here too, frequent objections have been heard to the mixing of peas of different va-

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Presented before the fifth annual convention of the Frozen Food Institute, New York City, 1946.

The author is research director of the Hospital Bureau of Standards and Supplies, New York City, and instructor in standards of supplies for hospitals, Extension Division, Columbia University.

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rieties and states of maturity. Excessive cooking of peas is frequently necessary because of the presence of overmature peas.

Some dietitians will not buy frozen corn because they prefer the flavor of cream style corn and are totally unsatisfied with the flavor of frozen kernel corn. This is one item that will not become popular in institutions until methods are developed which will retain some of the original sweetness and palatability of the natural product.

While some dietitians are buying considerable quantities of frozen broccoli, others will have none of it. The more critical complain of loss of color and flavor in cooking and state that they will continue to use fresh broccoli until something better is provided in the frozen product.

Few hospitals are purchasing frozen cauliflower. Cauliflower has a delicate flavor which is not retained after being frozen and cooked. Also, it does not retain its texture but becomes mushy when cooked.

Fresh brussels sprouts are, in the opinion of most dietitians, far superior to frozen brussels sprouts. The loss of color and the lack of flavor of the cooked sprouts make them an unpopular frozen item.

Want Specific Information

Dietitians who are well informed about the quality of frozen food and are exacting in their requirements insist that the container should carry information as to the variety of the product in the package. This, they feel, is needed most of all for peas, corn and lima beans. This information, coupled with a statement as to the grade of the product, would enable the buyer to judge the quality being offered without resorting to purchasing samples or trying the product of one company and then another.

One outstanding dietitian in the institutional field informed me that she found it necessary, in order to obtain the quality she wanted for each product, to purchase 10 or 12 different brands of frozen fruits and vegetables. Prior to placing orders for substantial quantities, samples of each had to be obtained and checked for quality. This is a time consuming, uneconomical buying procedure which is not calculated to promote the best interests of frozen food processors.

By and large, fewer complaints were registered regarding frozen fruits than was true of frozen vegetables. Frozen peaches and apricots are considered of excellent quality, although some dietitians have had unfortunate experiences with peaches which were apparently overripe when frozen. Comments on frozen apples were also favorable for the most part. It is my impression that the variety of peaches most frequently frozen is the freestone which has a flavor much superior to the canned clingstone. It is to be hoped the frozen food industry will avoid one of the practices sometimes resorted to by the canning industry: that of developing and processing varieties which hold their shape and give a good appearance but which have poor flavor and the texture of synthetic rubber.

Frozen berries are becoming quite popular with institutional dietitians. However, one complaint has been heard on numerous occasions, *i.e.* that the berries after being thawed are combined with too much juice. Whether this is due to a retention of an excess amount of water accumulated during the blanching process or whether it is the result of the dehydration of the berry during freezing is difficult to determine. I do know that dietitians are not satisfied with the present product.

Enthusiasm has been expressed on several occasions for frozen cherries, both pitted and with pits. In a few instances, mention has been made of cherries that were received dark in color, indicating that they had been refrozen. That complaint has also been made in connection with other types of frozen products. It would appear that it is not uncommon for frozen food, during the time it is being transported, to have thawed excessively and then to have been refrozen. This, I realize, may happen occasionally under present transportation conditions, but until this problem is solved the consumer will not have complete assurance of the quality and purity of the frozen food being consumed.

The question of what constitutes acceptable nutritive value in frozen foods is a difficult one to answer. It is generally assumed by dietitians that most frozen fruits and vegetables have a higher nutritive value than have the canned variety and much of the fresh produce. This assumption has, I believe, been corroborated by the research on various types of processed foods.

The differences, however, are not in all cases as great as they should and could be. The frozen food industry has built its reputation on processing fruits and vegetables at the moment of their prime maturity, keeping the product frozen under conditions that will prevent the loss of any of its quality and nutritive factors and delivering it to the consumer in a condition almost equal in every respect to the fruit or vegetable that was harvested in the field.

The frozen food industry should take whatever steps are required to maintain the superior nutritive value of its products. May I suggest one forward step that seems feasible and would give this industry a standing that no other processed foods industry can meet? I submit the possibility of establishing minimum standards for ascorbic acid content of certain frozen fruits and vegetables. Initially, such standards might be applied to only a limited number of vegetables.

Eight Brands Don't Meet Standards

This suggestion has also been made by authorities who have studied the problem closely and recognize its importance in judging the quality of fruits and vegetables. A precedent has been established by the Council on Foods and Nutrition of the American Medical Association which recently set up standards for minimum vitamin C content of tomato juice. A recent report showed that eight well known brands of tomato juice failed to meet these minimum standards.

Vitamin C content is an indication of proper growing conditions, state of maturity, correct or incorrect handling and careful or haphazard delivery. It also gives a rough indication of the degree to which other vitamins are retained in a particular fruit or vegetable. I believe the establishment of minimum standards and the declaration of ascorbic content are feasible and of inestimable value in promoting the use of frozen food among institutions, particularly hospitals.

Surely the day is coming when greater emphasis will be placed upon retaining vitamins in the foods we consume and less and less upon taking pills to offset the deficiency of

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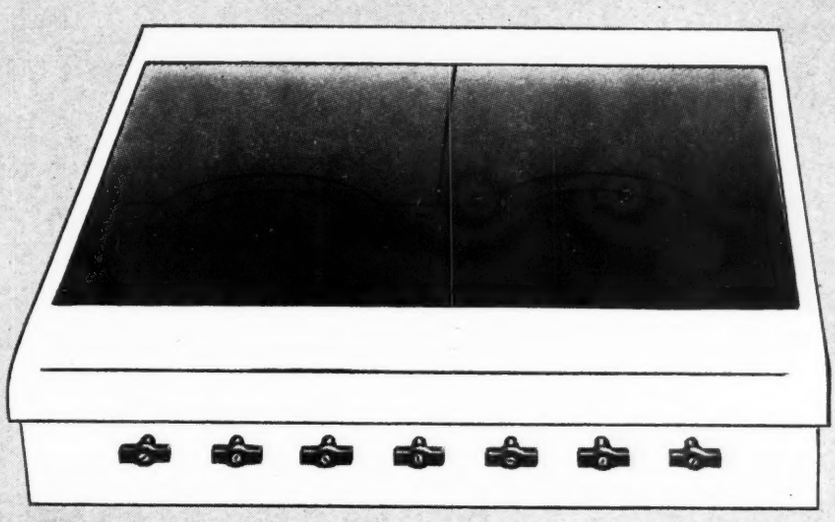

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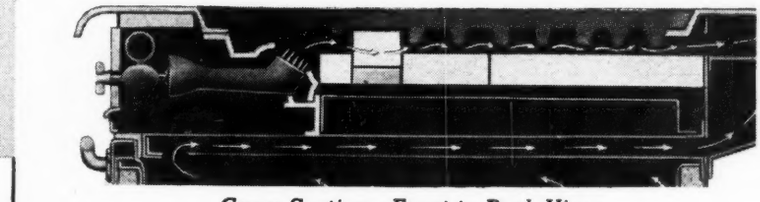

Cross Section—Front to Back View

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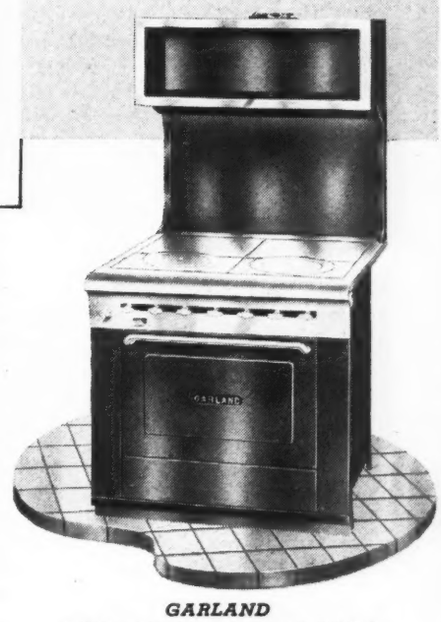

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vitamins in our regular diet. If emphasis on vitamin content will sell pills, it should also sell natural food products.

Emphasis should be placed, too, upon the need for a closer check and more careful regulation of the bacterial content of all types of frozen foods. In some present day plants operating under a heavy demand for more and more frozen food thorough sanitary conditions are not maintained and blanching processes are sometimes slighted, with the result that the bacterial count rises to high levels. Minimum standards for bacteria per gram must be established and maintained.

Simplifying and standardizing containers for frozen food products is a necessary step, both in handling and storing and in the preparation of the product. There is almost universal agreement among institutional buyers that the 2½ and 5 pound packages for frozen vegetables are the only sizes required. In fact, most dietitians prefer the 5 pound packages. Larger sizes are undesirable because of the difficulty in thawing and the tendency for the vegetables on the outside to become mushy before the thawing process has been completed.

Thirty pound packages are acceptable for most frozen fruit. Although some institutions are experiencing difficulties in defrosting 30 pound packages of peaches, the question of some softness when the fruit is to be used in pies is not particularly important. Most dietitians agree that only three sizes are needed for frozen fruit, namely, 5 pound, 10 pound and 30 pound packages.

Storage facilities for all types of frozen food are already a problem in many institutions. Objections are frequently raised to the wide variety in the sizes and shapes of packages. Round containers take up an excessive amount of room. One of the first projects of the frozen food industry might well be that of establishing standard sizes and shapes for all frozen food packages. Most institutions have limited frozen food storage capacity and the space available must be used to achieve maximum efficiency.

Probably as important as any other consideration is the need for instructing institutional dietitians about correct methods of handling and preparing frozen food. This is one of the weakest parts of the program of the frozen food industry at the present time. Information is vitally needed on the following subjects:

1. What constitutes quality in frozen food and how is it to be determined and compared by the purchaser?
2. What grades of frozen food are being processed at the present time? What is the relative value of these grades and how do they fit into the dietary plans of the hospital?
3. What storage facilities are needed in an institution of a given size for the most economical use of frozen food?
4. What are the best storage conditions for maintaining all the varieties of frozen foods in an institution?
5. What procedure should be followed in defrosting and preparing frozen fruits and vegetables in the institutional kitchen?

A. H. A. Food Service Institute

MEMO TO MANAGING EDITOR:

WE WENT to most of the talks at the A.H.A. Institute on Design, Construction and New Equipment for Food Service in Hospitals in Chicago, December 2 to 6. Many of those we heard were topnotch; the chances are we missed some good ones, too. Only a few failed to hit the mark.

The big room was jammed. More than 150 dietitians, stewards, architects and hospital superintendents came, took notes, agreed and disagreed with speakers. Margaret Gillam and the A.H.A. should be right proud of themselves.

We picked up so much good stuff that we haven't space for half of it. Maybe our readers would get more for their money by just reading our notes than if we wrote a running story complete with fill-ins, grammar, transitions, etc. What do you say?—M.W. and J.B.

DESIGN

NATHANIEL OWINGS, *architect*

Four steps in planning hospital food service:

1. Develop a planning team, consisting of administrator, medical director, dietitian, architect and special consultant.
2. Find a new approach by looking into other fields: Chrysler's, Macy's, Field's.
3. Think big. Be fearless of public opinion, which always follows tradition.
4. Be prodigal with blueprint paper. Study plans, build models.

Owings favors floor kitchens, which cost more but make the food look better to the patient. Is dead against tray conveyors. Sees no disadvantage in transporting food in carts to floor kitchens on sixth floor.

Every hospital food service plan should be different; stock plan won't do.

Why not place the cafeteria for nurses and doctors on the roof so that they will get a good view? Audience howled him down on that. It isn't democratic to favor those groups, said some.

In a neuropsychiatric hospital now being planned by Skidmore, Owings and Merrill, food is to be transported by electric truck through tunnels. Tunnel will provide insulation for cooling and heating. Maintenance will be low; no painting required. Owings thinks that in the next ten years hospitals will decentralize sites and thus more horizontal transportation will be needed. As for vertical transportation, segregate it.

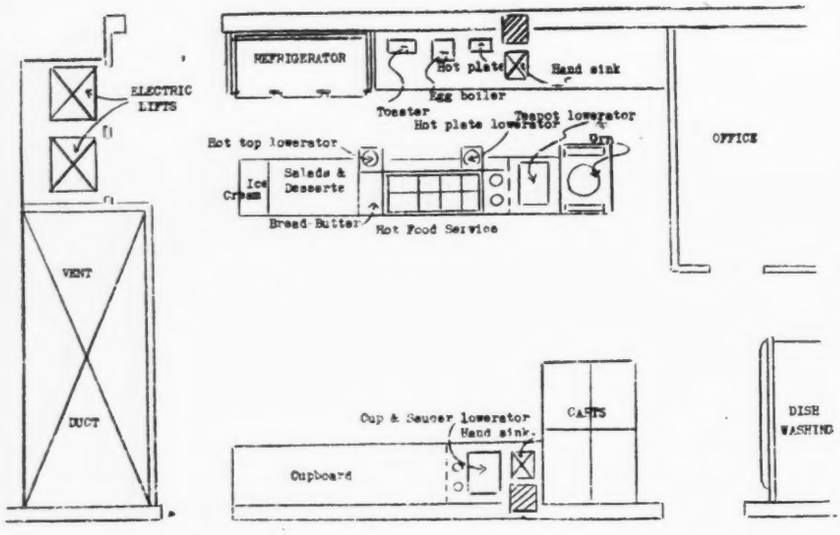
In future developments, the majority contribution of the architect will be complete flexibility of space. The loft building is the solution to our mechanized civilization.

Bob: I don't quite get him; one time, he said trend is toward decentralized sites; next he said loft building is "tops."

MARIAN WILLISCH, *interior architect*

Basis of all good architecture, interior *and* exterior, is functionalism; does not need to stop there. What should be sought in hospital dining room?

1. Atmosphere of rest and relaxation.
2. Feeling of security.
3. Stimulation.
4. Festive atmosphere.



A modern interpretation of a floor service kitchen. An effort has been made to locate all equipment so that trays can be served with the fewest possible movements. Facilities for dish and silver sanitation are adequate.

First two characteristics most important in hospital dining room. Basic principles in achieving this ideal are:

1. Should be planned for adequate serving and working space, with comfort uppermost.
2. Individual requirements.
3. Everything should be selected for purpose and use. If selected with understanding, beauty takes care of itself.
4. Sound value and quality, not cheap effect.
5. Appropriate to time and era, *i.e.* contemporary.
6. Should have charm and interest.

Space itself is most important. Approach must be "architectural," not "arty."

Consider new materials in planning: plastics, plywood, laminated woods, textiles, building materials, such as cement block. New materials need new approach, new esthetic outlook as form and design change.

New designs permit opening of the area to light and air but need not lack intimacy and protection. Space planning takes care of technical aspects and interior architecture can make seating arrangements follow a certain rhythm and overcome barn-like effect of too large empty space.

For walls, use finish of construction materials. Organization and contrasting materials help. Plastic wallpaper stresses texture, makes interesting treatment. Glazed, washable matting is durable and practical material. Don't use design all over; use sparingly. Separate work and service areas from eating areas by use of movable partitions, draperies, seating arrangements.

Showed slides of modern European hospitals and restaurants demonstrating use of large spaces with glass picture windows, giving impression of outdoors moved in. Showed panels of new materials used to create interesting wall effects. Contrasting materials and colors on different walls, *i.e.* textiles draped on one wall, rough plaster on another. Audience left with mouths hanging open.

ALLEN WILSON, *sound engineer*

Noise is "unwanted sound." Has deleterious effect on the system of well person; ill effect intensified with sick. Doctor at Kings County Hospital, Brooklyn, put on three month campaign to reduce noise. Believed in many cases length of stay reduced two days because quieter atmosphere promoted rest and consequent healing.

Three things that a hospital can do about noise:

1. Diminish at source.

By special hardware (door closers, etc.), noiseless wall switches, rubber-edged elevator doors, silent water valves, resilient floors, rubber coated trays in utility rooms, casters on furniture.

2. Isolate.

By placing such noisy areas as utility rooms, kitchens and service areas away from patient areas.

3. Absorb.

With acoustical materials. Place to start is in CORRIDORS which act like speaking tubes, carrying sounds out of and into patients' quarters. Other important points are KITCHENS, UTILITY ROOMS, NURSES' STATIONS, LABOR, DELIVERY AND OPERATING ROOMS. Debatable whether patients' rooms need acoustical material.

Material should be paintable, durable, easy to clean. Cost of treating a new hospital, not including patients' rooms, approximately 1 per cent of total cost; with patients' rooms, approximately 1½ per cent.

Answering the objection that acoustical treatment is not desirable in kitchens because grease and vermin can take up residence in holes, Wilson pointed out that the holes do not go all the way through and that an air plug keeps out dirt and water. The material should be painted with an oil or enamel paint for best maintenance.

FLOOR SERVING KITCHENS

MARTHA NELSON LEWIS, *dietitian*

In large hospital, don't put several serving kitchens on one floor. Centralize them in small central service unit. Gives advantages of central tray service without certain disadvantages.

Keynote in arranging equipment is logical sequence in handling and routing food, preventing rehandling and criss-crossing.

Don't arrange all equipment around the walls. Arrange in assembly line, resembling cafeteria counter. (See floor plan.)

Dietitian, her patients, her office and her serving kitchen should all be on same floor. Basement office taboo.

(To be continued.)

Food for Thought

Of Interest to Dietitians

A 287 page manual, "Establishing and Operating a Restaurant," written for the War Department by Mary DeGarmo Bryan, Alberta M. Macfarlane and E. R. Hawkins, is now obtainable for 45 cents (not in stamps) from the U. S. Superintendent of Documents, Washington 25, D. C.

The manual is expected to become a textbook for college courses in institution management and in hotel and restaurant administration. It is said to contain information never before set forth in such a book.

Much of the material is of interest to dietitians, as it contains chapters on kitchen and dining room layout, personnel policies, menu planning, food purchasing, quantity cooking, sanitation, care of equipment, food cost records and time tables for cooking.

In order to make the manual available for general distribution to the public, the War Department authorized the use of type and illustrations by the bureau of foreign and domestic commerce, U. S. Department of Commerce.

Menus for February 1947

Edith Coyne
Parkview Hospital
Pueblo, Colo.

1
Half Grapefruit
Scrambled Eggs
•
Pot Roast of Beef,
Vegetable Gravy
Mashed Potatoes
Baby Lima Beans
Diced Beets
Cottage Pudding With
Fruit Sauce
•
English Beef Broth With
Barley
Mock Chicken Salad,
Crackers
Sweet Pickle Chips
Hot Rolls
Canned Peaches, Cookies

2
Fresh Applesauce
Crisp Bacon
•
Roast Young Chicken With
Celery Dressing, Gravy
Parslied Potatoes
Frozen Peas
Cranberry Sauce
Fruit Salad
Strawberry Sundae, Cookies
•
Oyster Stew, Crackers
Combination Salad
Hot Rolls
Chocolate Fudge Cake

3
Pineapple Juice
Soft Cooked Eggs
•
Roast Leg of Lamb,
Mint Sauce
Baked Stuffed Potatoes
Glazed Carrots
Stewed Tomatoes
Apple Cobbler
•
Potage Julienne
Egg à la Goldenrod on
Toast Points
Asparagus Spears-
Pimiento Salad
Oatmeal Cookies

4
Blended Fruit Juice
Bacon Strips
•
V-8 Cocktail
Swiss Steak
Riced Potatoes
Buttered Parsnips
Lettuce Hearts, Chiffonade
Dressing
Raspberry Gelatin,
Whipped Cream
•
Chicken Noodle Soup
Baked Stuffed Peppers
With Gravy
Banana Nut Salad
Pineapple Squares

5
Tomato Juice
Poached Eggs
•
Breaded Veal Cutlets
Oven-Browned Potatoes
Boiled Onions
Mashed Hubbard Squash
Peaches and Cream
Pudding
•
Cream of Pea Soup
Cream Cheese and Jelly
Sandwiches
Peanut Butter Sandwiches
Julienne Vegetable Salad
Canned Apricot Halves,
Cookies

6
Sliced Oranges
Cinnamon Toast
•
Meat Loaf With Mushroom
Gravy
Escalloped Potatoes
Frenched Beans
Celery Hearts, Carrot
Sticks
Lemon Chiffon Pie
•
Scotch Broth
Creamed Chipped Beef on
Baked Potato
Head Lettuce, Thousand
Island Dressing
Macaroons

7
Tokay Grapes
Hot Muffins
•
Broiled Fillet of Sole,
Lemon Slice
Chateau Potatoes
Creamed Corn
Sliced Tomato Salad
Orange Sherbet, Cookies
•
Potato Chowder
Salmon Patties, Cream
Sauce
Blushing Pear Salad
Butterscotch Pudding
With Cream

8
Stewed Figs
Soft Cooked Eggs
•
Broiled Yearling Liver
With Onion Gravy
Mashed Potatoes
Cauliflower Paprika
Asparagus Tips
Apricot Upside-Down
Cake
•
Lamb Broth à la Grec
Italian Spaghetti With
Parmesan Cheese
Perfection Salad
Pan Rolls
Fresh Fruit Cup

9
Sliced Bananas
Bacon Strips
•
Roast Prime Ribs of Beef
Au Jus
Snowflake Potatoes
Julienne Carrots
Wax Beans
Assorted Olives
Blueberry Sundae, Cookies
•
Tomato Boullion
Creamed Sweetbreads on
Toast
California Salad
Brownies

10
Half Grapefruit
Cinnamon Toast
•
Fricassee of Chicken
Steamed Rice
Buttered Spinach
Harvard Beets
Apple Brown Betty With
Cream
•
Oxtail Soup
Shepherd's Pie
Coleslaw With Pineapple
Red Raspberry Gelatin
With Whipped Cream

11
Stewed Prunes
Omelet
•
Mustard Pickles
Baked Sugar Cured Ham
With Raisin Sauce
Mashed Sweet Potatoes
Braised Celery
Frozen Peas
Chocolate Ice Cream
•
Alphabet Soup
Grilled Beef Patties in
Bacon Strips
Tomato Aspic Salad
Hot Rolls
Iced Cup Cakes

12
Apricot Nectar
Soft Cooked Eggs
•
Pan Broiled Lamb Chops
Potato Cakes
Baked Acorn Squash
Spring Salad
Fresh Pear
•
Vegetable Soup
Toasted Cheese Sandwich
Potato Chips
Molded Cherry-Nut Salad
Banana Cream Pie

13
Orange Halves
Hot Muffins
•
Braised Beef Tongue With
Vegetable Gravy
Franconia Potatoes
Mashed Rutabaga
Buttered Green Beans
Baked Peach Turnover
•
Spanish Bean Soup
Escalloped Ham and Eggs
Celery Curls, Radishes
Hot Rolls
Vanilla Wafers

14
Fresh Applesauce
Scrambled Eggs
•
Broiled Salmon Steak
Mashed Potatoes
Grilled Tomato Slices
Buttered Cabbage
Pineapple Milk Sherbet,
Cookies
•
Purée of Split Pea Soup
Escalloped Oysters en
Casserole
Valentine Salad
Canned Cherries

15
Grapefruit Juice
Crisp Bacon
•
Ragout of Veal
Parslied Potatoes
Baby Green Lima Beans
Grated Carrot-Raisin
Salad
Danish Pastry
•
Cream of Celery Soup
Cold Cuts
Hashed Brown Potatoes
Pickled Beet Salad
Lemon Sponge Pudding

16
Pineapple Juice
Toasted Raisin Bread
•
Broiled Minute Steak
Baked Stuffed Potatoes
Red Pepper Relish
Whole Kernel Corn
Pear-Pimiento Salad
Chocolate Sundae, Cookies
•
Cream of Asparagus Soup
Baked Macaroni and
Cheese
Tomato Wedges on Lettuce
Salad
Burnt Sugar Cake,
Boiled Icing

17
Canned Prune Plums
Soft Cooked Eggs
•
Roast Shoulder of Fresh
Pork, Applesauce
Mashed Potatoes
Buttered Cauliflower
Sliced Beets
Graham Cracker Pudding
•
Pepperpot Soup
Escalloped Potatoes and
Hamburger
Tossed Vegetable Salad
Baked Apple With Cream

18
Sliced Bananas
Poached Eggs
•
Old Fashioned Chicken Pie
Mashed Potatoes
Julienne Green Beans
Waldorf Salad
Glorified Rice Pudding
•
Cream of Spinach Soup
Nut Bread-Cream Cheese
Sandwiches
Meat Salad Sandwiches
Grapefruit-Cherry Salad
Lemon Drop Cookies

19
Half Grapefruit
French Toast
•
Ham Loaf, Tomato Sauce
Oven-Browned Potatoes
Broccoli, Hollandaise
Sauce
Diced Carrots
Blueberry Cobbler
•
French Onion Soup With
Croutons
Corn Pudding, Bacon Strip
Tiny Green Bean-Pimiento
Salad
Pineapple Squares

20
Tokay Grapes
Bacon Strips
•
Roast Leg of Lamb, Mint
Jelly
Creamed Potatoes
Frozen Peas
Stewed Celery
Tropical Fruit Gelatin
With Whipped Cream
•
Beef Tea
Chicken à la King
Raw Carrot Sticks, Olives
Hot Rolls
Canned Pears, Cookies

21
Prune Juice
Scrambled Eggs
•
Fried Fillet of Halibut,
Tartare Sauce
Baked Potatoes
Breaded Tomatoes
Mashed Hubbard Squash
Orange Sherbet, Cookies
•
Mulligatawney Soup
California Tuna Pie
Celery Stuffed With
Roquefort Cheese
Boston Cream Cake

22
Apple Juice
Bacon Strips
•
Baked Stuffed Beef Heart
With Gravy
Whipped Potatoes
Glazed Parsnips
Green Asparagus Tips
Cherry Pie
•
Washington Chowder
Spanish Omelet
Fruit Salad, Whipped
Cream Dressing
Hot Rolls
Blueberry Cup Cakes

23
Stewed Apricots
Soft Cooked Eggs
•
Celery Hearts
Roast Leg of Veal With
Brown Gravy
Chateau Potatoes
Escalloped Cabbage
Buttered Green Beans
Pineapple Sundae, Cookies
•
Chicken Broth With Rice
Tomato-Bacon-Lettuce
Sandwiches
Peach-Cream Cheese
Salad
Coconut Layer Cake

24
Orange Juice
Shirred Eggs
•
Broiled Chopped Steak
With Mushroom Gravy
Franconia Potatoes
Baked Acorn Squash
Grapefruit-Cherry Salad
Spiced Watermelon Rind
Graham Cracker Pudding
•
Strained Gumbo Soup
Escalloped Salmon and
Noodles
Apple-Raisin Salad
Hot Rolls
Butterscotch Icebox
Cookies

25
Stewed Figs
Omelet
•
Roast Pork Tenderloin,
Apple Rings
Baked Sweet Potatoes
Diced Beets
Brussels Sprouts
Jelly Roll
•
Cream of Mushroom Soup
Baked Rice and Cheese
Molded Carrot-Pineapple
Salad
Tokay Grapes

26
Blended Juice
Bacon Strips
•
Shepherd's Pie With
Vegetables
Stewed Tomatoes
Spiced Coleslaw
Steamed Chocolate
Pudding, Custard Sauce
•
Essence of Celery Soup
Hamburger Roll With
Relish
Kidney Bean, Diced Egg
Salad
Old Fashioned Cookies

27
Half Grapefruit
Bran Gems
•
Broiled Liver and Bacon
Riced Potatoes
Fried Eggplant
Frozen Peas
Whipped Cream Puff
•
Veal Broth With Rice
Grilled Lamb Patty,
Pineapple Ring
Mixed Green Salad
Hot Rolls
Dutch Apple Cake,
Cinnamon Sauce

28
Sliced Bananas
Scrambled Eggs
•
Baked Fillet of Red
Snapper au Gratin
Baked Stuffed Potatoes
Boiled Onions
Asparagus Tips
Raspberry Sherbet, Cookies
•
Alphabet Soup
Vegetable Plate: Broiled
Tomato, Green Beans,
Tiny Whole Carrots
Cottage Cheese Salad
Apricot Whip, Custard
Sauce

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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PATIENT BILLY: Gee whiz! I don't even miss my appendix. And I get Kellogg's cereals for breakfast, same as at home. I *like* it here! (Note: More kids eat Kellogg's than any other cereals.)

NURSE CARTER: I've got to make every minute count. That's why Kellogg's Individuals are a nurse's best friend. Save time—and dishes. They're sanitary, too. 'Scuse me. There goes my buzzer!

DIETITIAN DENNIS: Kellogg's cereals with milk provide excellent nutrition—and they're so easy to digest. Patients love the appetizing assortment. Confidentially, so does *this* lady.

GRAND NUTRITION: All Kellogg's cereals either are made from whole grain, or are restored with whole-grain nutrients declared essential to human nutrition, in accordance with the U. S. Nutrition Program.

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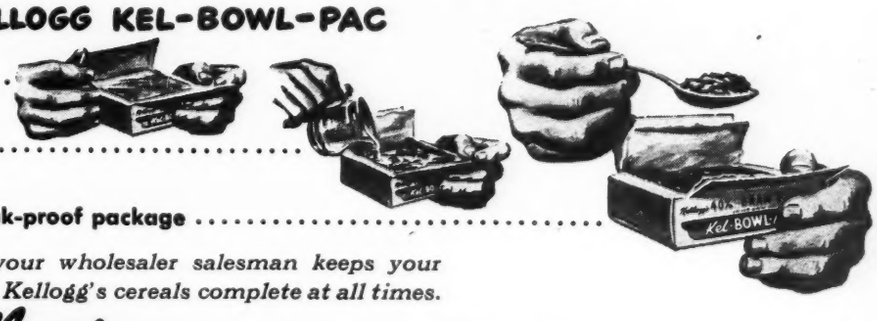
THE EXCLUSIVE KELLOGG KEL-BOWL-PAC

1. Open the package....

2. Add cream and fruit.....

3. Eat right out of the leak-proof package .....



Be sure your wholesaler salesman keeps your variety of Kellogg's cereals complete at all times.

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PLANT OPERATION & MAINTENANCE

What Kind of *Walls and Wainscots* Do You Want?

EVERETT W. JONES

IN THE December issue, the preferences of a group of architects and administrators regarding floors and ceilings were presented and analyzed. The following material deals with the views of this same group (based on the returns from a comprehensive questionnaire) on treatment of walls and wainscots.

WALLS AND WAINSCOTS

Walls: Patients' Rooms	*No.*	*%*	
Painted plaster	78	55	
Fabric, washable	41	30	
Papered	4	3	45%
Plastic	6	4	
Miscellaneous	10	7	
Wainscots: Patients' Rooms	*No.*	*%*	
Painted plaster	40	49	
Plastic	11	14	
Rubber	9	11	51%
Glazed block	5	6	
Miscellaneous	16	20	

Although 51 per cent of the replies on the wainscot question expressed a preference for special material for wainscots, this represents only 41 out of 139 answers to the preceding question on walls.

In other words, only 30 per cent of those answering the wall question want a special material (other than regular painted plaster) for wainscots. Considering the greatly reduced wall maintenance cost when indestructible wainscot materials are used, this is a small percentage. Probably the element of appearance in private rooms has influenced the choice.

Walls: Wards	*No.*	*%*	
Painted plaster	87	65	
Fabric, washable	23	17	
Plastic	6	5	35%
Miscellaneous (including 4 for asphalt tile)	17	13	
Wainscots: Wards	*No.*	*%*	
Painted plaster	40	44	
Plastic	13	14	
Linoleum	6	7	
Rubber	9	10	
Glazed block	8	9	55%
Ceramic tile	5	6	
Miscellaneous (including 4 for asphalt tile)	9	9	

In this question, more than half (55 per cent) of the replies gave evidence by their choice of some wainscoting material other than plaster of appreciating the maintenance cost reduction of damageproof wainscots. However, only 37 per cent of all those answering the wall question showed preference for such wainscots. Considering the favorable factors of low first cost, ease of application and maintenance, and greatly reduced maintenance cost, it is surprising that a higher vote was not recorded for linoleum on wainscots. Manufacturers have developed a special thin-gauged linoleum especially for walls. This is an ideal wainscot material.

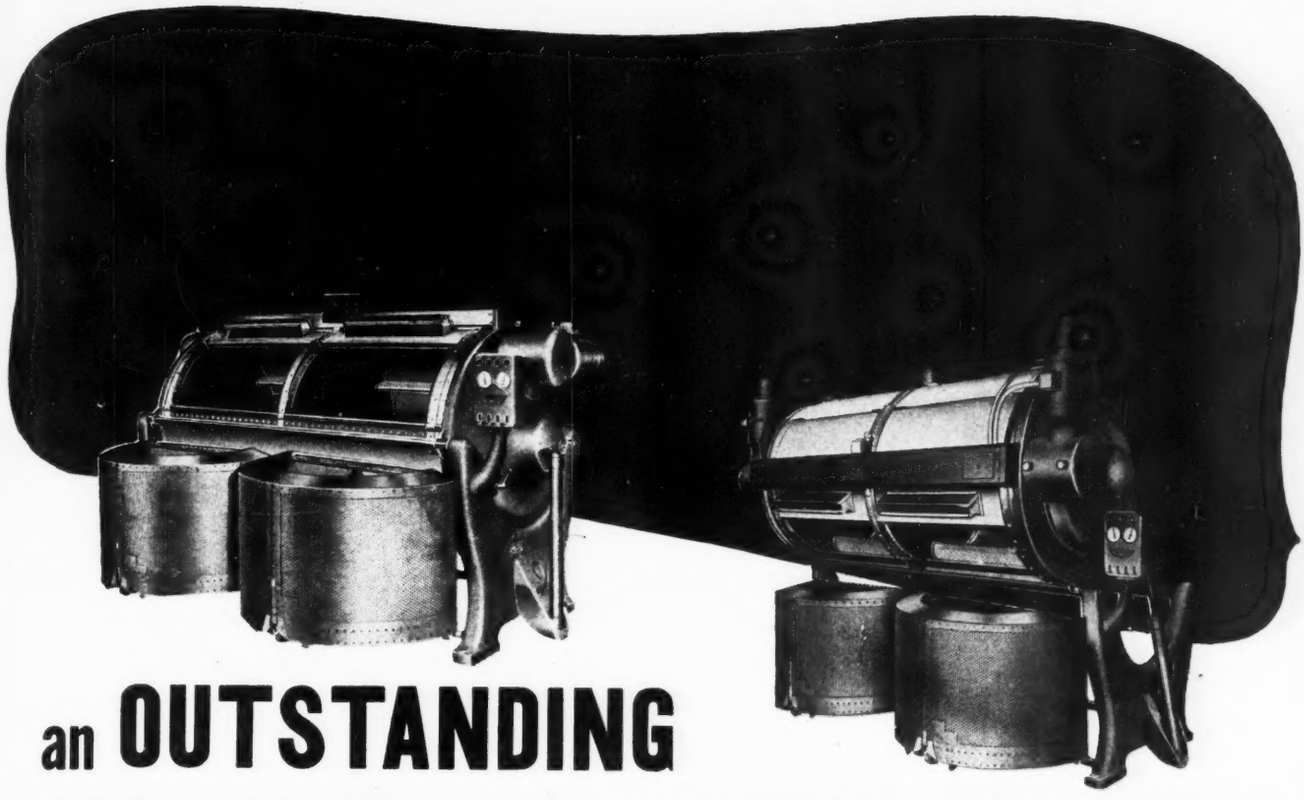
Walls: Corridors, Patients' Floors			
Painted plaster	80	57	
Fabric, washable	14	10	
Glazed block	13	9	
Structural glass	9	6	42%
Plastic	7	5	
Miscellaneous	17	12	

Wainscots: Corridors, Patients' Floors	*No.*	*%*	
Painted plaster	25	25	
Rubber tile	15	15	
Ceramic tile	15	15	
Glazed block	13	13	
Plastic	13	13	75%
Linoleum	6	6	
Asphalt tile	5	5	
Miscellaneous	7	7	

The fact that 75 per cent of those answering this question voted for some type of damageproof wainscoting material indicates that thought is being given to the necessity of reducing prevalent high wall maintenance costs in busy corridors. Of the 140 answers to the corridor wall question, 74, or 54 per cent, voted for damageproof wainscots as against 30 per cent on patients' rooms and 37 per cent on patients' wards.

Experience has shown that from 70 to 75 per cent of all wall maintenance cost in multiple bedrooms (semiprivate and ward) and patients' corridors is confined to an area from 4½ to 5 feet above the floor.

Those who have studied this problem believe that from 60 to 65 per cent of wall maintenance cost can be eliminated by using damageproof, easily washable wainscots. Such materials require no plaster patching or painting. While many would hesitate to use such wainscots in the higher priced private rooms, I can see no reason for hesitancy in using them in all multiple bedrooms and patients' floor corridors. Wall damage from beds, chairs, stretchers and dirty hands is greatest in corridors



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ACHIEVEMENT IN LAUNDRY EQUIPMENT

The Hoffman "Unloading Silver Crest" Washer gives you greatly increased production at a much lower cost for labor. You save virtually all the time usually required for pulling the wet load from the cylinder. This also means less strains on linens because hand pulling is eliminated and when used with unloading extractors, even greater savings are effected.

The Hoffman "Unloading Silver Crest" is the most simple unloading washer ever built. Cradle frame unloading permits both cylinder and shell to elevate to the unloading position without any strain or distortion on the cylinder or shell because all complicated mechanical lifting apparatus has been eliminated.

Increased production — unloading time and labor saved means a more economical operation for you.

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and multiple bedrooms. Even the high grade, extremely durable washable fabric wall coverings now so widely used are no match for the banging that walls get at the wainscot levels.

Washable wall coverings or a high grade semigloss paint above a dampageproof wainscot give an attractive wall with low maintenance cost.

Walls: Corridors, Heavy Trucking	*No.*	*%*	
Painted plaster	45	34	
Brick	24	18	
Glazed block	27	21	
Ceramic tile	8	6	65%
Plastic	5	4	
Tile board	5	4	
Miscellaneous	16	12	

Wainscots: Corridors, Heavy Trucking	*No.*	*%*	
Glazed block	26	25	
Brick	15	15	
Ceramic tile	13	13	
Rubber	9	9	
Plywood	8	8	87%
Metal	7	7	
Plastic	6	6	
Miscellaneous	4	4	
Painted plaster	14	14	

The percentage of votes for painted plaster for walls or wainscots in the heavy trucking area corridors is lower than for any of the areas given before. Why anyone at all would vote for plaster wainscots in these corridors is hard to understand inasmuch as painted plaster walls in heavy trucking corridors just can't be kept in repair. George Behm, the mechanical superintendent at Albany Hospital, Albany, N. Y., solved the problem by installing medium weight steel plate wainscots in these corridors.

Plaster walls with holes gouged out and paint scratched off present a disreputable appearance. For the sake of employe morale, the appearance of the "back of the house" must be kept up.

Walls: Utility and Work Rooms	*No.*	*%*	
Painted plaster	43	33	
Ceramic tile	30	23	
Glazed block	24	19	
Brick	6	5	
Tile board	6	5	65%
Structural glass	6	5	
Linoleum	6	5	
Miscellaneous	4	3	

Wainscots: Utility and Work Rooms	*No.*	*%*	
Ceramic tile	25	27	
Glazed block	22	24	
Rubber	7	8	
Plastic	9	10	85%
Linoleum	5	5	
Miscellaneous	10	11	
Painted plaster	13	14	

Anyone who has looked at plaster walls or, at least, plaster wainscots, in hospital utility rooms would be justified in wondering why plaster and paint would ever be selected for wainscots in these units. Nothing can be more depressing to employe morale than the daily sight of peeling paint and broken plaster. The worst looking utility room can be spruced up by covering the unsightly walls with one of the several excellent tile boards or other impervious material now available.

Walls: Operating and Delivery Rooms	*No.*	*%*	
Ceramic tile	47	38	
Structural glass	22	18	
Glazed block	15	12	
Tile board	5	4	79%
Plastic	5	4	
Linoleum	4	3	
Painted plaster	26	20	

Wainscots: Operating and Delivery Rooms	*No.*	*%*	
Ceramic tile	43	51	
Glazed block	18	21	
Rubber	5	6	
Plastic	6	7	93%
Miscellaneous	7	8	
Painted plaster	6	7	

Apparently most hospital administrators realize the value of wainscots that are damageproof, easily washable and inexpensive to maintain in operating and delivery rooms. Those who voted for painted plaster should give this problem further study and thought.

I have recently seen several operating room walls covered from baseboard to ceiling with a special type of linoleum made for wall coverings. Although this material was originally developed for wainscots in corridors and other "hard usage" locations, it looked and was performing quite well as a covering for the entire operating room wall.

Some persons prefer to cover the entire wall instead of just the 6 or 7 foot wainscot with an impervious material. Although the subject is debatable, the question of painting costs over the years on walls that must be frequently washed must always be kept in mind. Walls that will never require painting may be an economy in the long run.

Walls: Kitchens	*No.*	*%*	
Glazed block	54	40	
Ceramic tile	25	19	
Structural glass	9	7	
Tile board	5	4	
Brick	4	3	81%
Linoleum	4	3	
Plastic	4	3	
Miscellaneous	3	2	
Painted plaster	26	19	

Wainscots: Kitchens	*No.*	*%*	
Ceramic tile	31	35	
Glazed block	29	33	
Plastic	5	6	86%
Rubber	4	4	
Miscellaneous	7	8	
Painted plaster	12	14	

Here, as in the operating room, a great majority prefer damageproof, easily washable walls or wainscots.

Walls: Laundry	*No.*	*%*	
Glazed block	40	31	
Brick	23	18	
Ceramic tile	13	10	79%
Structural glass	9	7	
Miscellaneous	16	13	
Painted plaster	26	20	

Wainscots: Laundry	*No.*	*%*	
Glazed block	29	31	
Brick	15	16	
Ceramic tile	11	12	
Plywood	8	8	84%
Plastic	7	7	
Rubber	5	5	
Miscellaneous	5	5	
Painted plaster	14	15	

Glazed block, brick and ceramic tile in the order named are the materials of choice in this area and experience proves their practicability from the standpoints of appearance and low maintenance cost.

Walls: Employe Washrooms	*No.*	*%*	
Glazed block	40	29	
Ceramic tile	23	17	
Structural glass	8	6	
Tile board	6	4	72%
Brick	6	4	
Plastic	5	4	
Miscellaneous	11	8	
Painted plaster	38	28	

Wainscots: Employe Washrooms	*No.*	*%*	
Glazed block	34	36	
Ceramic tile	25	27	
Plastic	6	6	86%
Asphalt tile	5	5	
Miscellaneous	11	12	
Painted plaster	13	14	

Administrators and architects who have made any real study of conditions in employes' washrooms and who appreciate the morale-building value of keeping these rooms clean

It's Monel in Jacksonville

. . . but it could just as well be your city

Jacksonville's Laundrymen say**...**

"Monel is long-lasting. It is practically a lifetime proposition."

"Monel is fast and lasts a lot longer."

"Monel is more economical in supplies and will carry a larger load."

"Wood wears out faster. Have to replace the cylinders too often."

"Monel is less trouble. Practically no upkeep."

"Monel is strong . . . never rusts . . . has good speed."

***These comments were made to representatives of an independent research organization during the course of a nationwide survey of power washing facilities in selected cities.**

Three of the hospitals in Jacksonville, Fla., operate their own power washing facilities. And Jacksonville has, in addition, 12 large commercial laundries.

How that compares with your city is not important. But this one fact is:

Jacksonville operators — in common with hospital laundry superintendents and commercial laundrymen from coast to coast — prefer Monel* above all other metals.

The proof? Eighty-eight per cent of all the metal washing machines in Jacksonville's laundries are Monel. Almost 9 out of every 10!

This popularity doesn't just *happen*. There are reasons for it. And if you're anxious to reduce hospital washroom costs, speed up service or improve the quality of your work, you'll want to know what those reasons are.

So . . . take 30 seconds to read the panel at the left. See what Jacksonville operators say about the washers they use. Note particularly their comments about Monel. Then compare these remarks with your own experience.

Monel* washers last longer. They require little maintenance and repair. They are rustproof. They resist corrosion. They help save labor and supplies, as well as steam, power and water.

That's why Monel is first choice of the experienced laundry superintendent. That's why it is so often chosen not only for washers, but also for extractors, starch cookers, laundry chutes and truck tubs. They all last longer and serve better when they're Monel.

*Reg. U. S. Pat. Off.

THE INTERNATIONAL NICKEL COMPANY, INC., 67 WALL STREET, NEW YORK 5, N. Y.

Monel . . . *standard metal of the laundry industry*

and neat would never vote for painted plaster wainscots. Damageproof material from the floor to a height of 6 or 7 feet is a *must*.

Walls: Employe Restrooms	*No.*	*%*	
Painted plaster	74	56	
Fabric, washable	18	13	
Glazed block	12	9	
Plastic	7	5	44%
Tile board	5	4	
Miscellaneous	17	13	

Wainscots: Employe Restrooms	*No.*	*%*
Painted plaster	31	30
Glazed block	18	18
Ceramic tile	12	12
Linoleum	11	11
Plastic	10	10
Rubber	8	8
Asphalt tile	7	7
Miscellaneous	5	5

70%

Here, again, we have a "back of the house" location that deserves careful consideration and treatment in keeping with needs of employes. Damageproof wainscots 4 feet 6 inches high are needed here also. For the walls above such wainscots, a good grade of paint in pleasing colors for the men's rooms and a colorful, decorative washable wall covering in the women's rooms would be good treatment.

Too much emphasis cannot be placed on the need for clean, attractive "back of the house" areas.

Walls: Administrative Suite	*No.*	*%*	
Painted plaster	77	60	
Fabric, washable	20	15	
Plywood	9	7	
Fabric, veneer faced	7	5	40%
Plastic	6	5	
Miscellaneous	11	8	

Wainscots: Administrative Suite	*No.*	*%*
Painted plaster	39	50
Plywood	13	16
Rubber	9	11
Plastic	7	8
Asphalt tile	4	5
Brick	4	5
Linoleum	4	5
Miscellaneous	2	2

50%

As I look at the walls in my office (painted just 30 days ago) I wish that a wainscot of plywood, linoleum, rubber, asphalt tile or some one of the new plastic materials had been installed to protect the walls up a little above the height of a chair. Painted plaster walls are easily and rapidly marred by chairs.

Walls: Public Lobbies	*No.*	*%*	
Painted plaster	71	50	
Fabric, washable	16	12	
Plastic	9	7	
Glazed block	7	5	
Plywood	6	5	50%
Fabric, veneer faced	6	5	
Ceramic tile	5	4	
Structural glass	4	3	
Miscellaneous	6	5	

Wainscots: Public Lobbies	*No.*	*%*
Painted plaster	37	41
Rubber	10	11
Plywood	10	11
Glazed block	9	10
Plastic	8	9
Ceramic tile	7	8
Asphalt tile	4	4
Miscellaneous	5	5

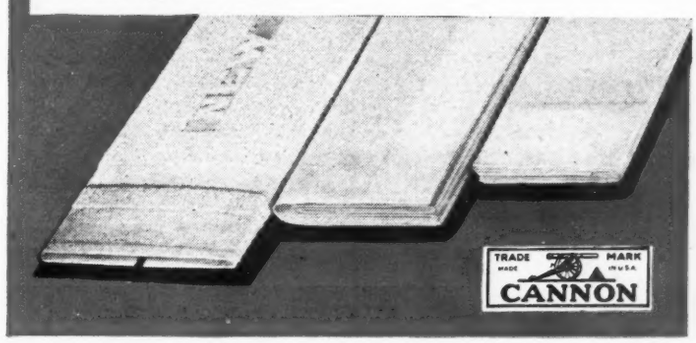
59%

We must never lose sight of the public relations value of attractive public lobbies. These areas should inspire confidence in patients and visitors.

Administrators, architects and maintenance superintendents should give a great deal of thought and study to all of the materials discussed in this report.

• *Founded in 1771, the New York Hospital moved into its present functional buildings in 1932 and associated with Cornell University Medical College. It has a distinguished teaching staff and an extensive research division. Provided in 1945 a total of 420,565 days of bed care.*

• **No detail of laundry procedure is too small to be considered. Ironer rollers must match to the millimeter. Out-size rollers pull unevenly, strain fabrics.**



Cannon

Towels and Sheets

NEWS DIGEST

Hospitals Must Come Up to Date in Dealing With Press, A.C.S. Conferees Told

Newspaper reporters seeking information from hospitals are commonly given a "run around," David Dietz, science editor of the Scripps-Howard newspapers, told the hospital standardization conference of the American College of Surgeons Clinical Congress, meeting in Cleveland the week of December 16. "Hospitals spend time and money modernizing physical plants but usually forget all about bringing their public relations up to date," Mr. Dietz declared.

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Cleveland Code Successful

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Dr. Russell Crawford of the Lakewood Hospital endorsed the objective of more friendly relations between hospitals and newspapers but warned that the patient's interest must always be considered ahead of news values.

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Dr. Frode Jensen of the American Medical Association staff underlined the importance of accurate histories, progress records and clinical charts in the training of interns and residents. Edna Huffman, Wesley Memorial Hospital, Chicago, outlined the objectives of the training program for medical record library employes in hospitals, sponsored by the American Association of Medical Record Librarians. She stressed the importance of short institutes for untrained hospital employes and discussed the courses already provided under the joint sponsorship of the Medical Record Librarians and the American Hospital Association.

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The conference also heard discussions of the current nurse problem by Dr. Robin C. Buerki of the University of Pennsylvania, Lucile Petry of the U. S. Public Health Service, James Stephan of the University of Minnesota and Edgar Blake Jr. of Wesley Memorial Hospital, Chicago.

Women M.D.'s Appointed

WASHINGTON, D. C.—Ten outstanding women doctors have been appointed as consultants on medical care for women veterans in V.A. hospitals and homes, it has been announced. The news came from Dr. Margaret D. Craighill, former dean of the Women's Medical College of Pennsylvania and chief consultant to the Veterans Administration on medical care for women veterans. This group, all veterans of World War II, will work with V.A. branch office and central office medical staffs in advisory capacities. It is intended that medical care for women veterans in V.A. hospitals and homes be kept at the highest possible standards.

V.A. to Inaugurate Advanced Courses in Tuberculosis Nursing

By EVA ADAMS CROSS

WASHINGTON, D. C.—A special curriculum in advanced tuberculosis nursing exclusively for Veterans Administration nurses is scheduled to begin at Western Reserve University, Cleveland, February 7. The course will be presented twice during 1947 from February 7 to May 8 and from May 16 to August 4.

Streamlined by eliminating electives, the course will terminate within the ninety day maximum period authorized for professional instruction under Public Law 293. It will carry 10 semester hours of collegiate credit and will include the following subjects: medical aspects of tuberculosis; nursing in tuberculosis, and nursing practice in clinical specialty.

Under Public Law 293, V.A. nurses selected for this advanced training will have their tuition, transportation and educational fees paid by the government. These are to be refunded if the nurse leaves the Veterans Administration within two years after completion of the course.

Army Surgeon General Reports on Streptomycin

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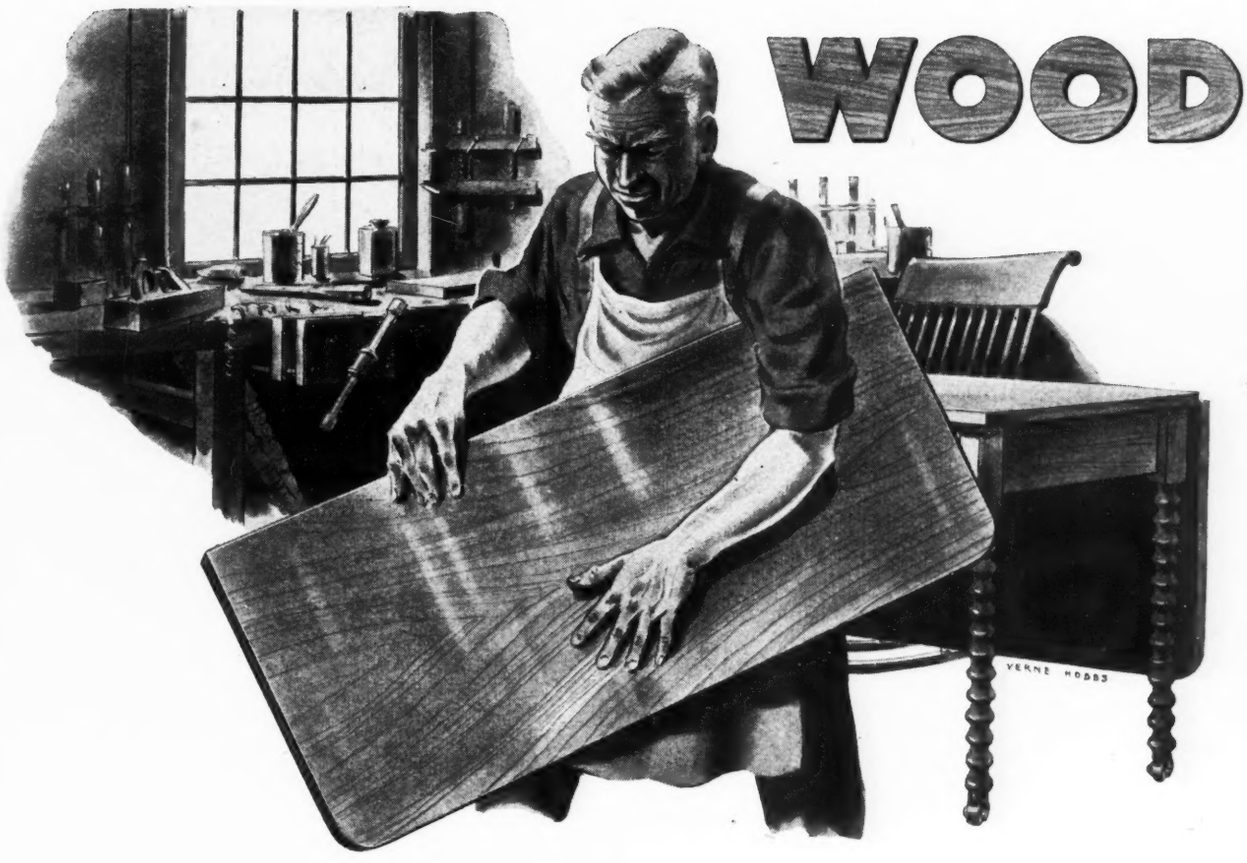
Army findings indicate that streptomycin has specific poisonous effects when given over an extended period and bacteria soon become resistant to it so that it probably can be used only once with maximum effect within a limited period on the same patient.

One of the hopes of the medical profession has been that streptomycin would prove of some value against tuberculosis. The surgeon general's office is not ready yet to confirm or refute its value in treatment of this disease. A much longer series of investigations will be required before there can be any valid conclusions.



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Wood is remarkable for its strength and lightness. Engineers find it a superior material where high resistance to bending or compression is needed. Because of these qualities wood, through the ages, has had no equal as a material for fine furniture.

Not only is wood unequalled for a strength that gives long life to furniture . . . it is also unequalled for *beauty*. Wood, when fashioned and formed, polished and finished, possesses in a high degree a charm comparable to that which inspires man's admiration for fine paintings and objets d'art.

Carrom, however, does still more with wood than capture its beauty and utilize its strength in the fine furniture Carrom craftsmen produce. Carrom fine wood furniture is made exclusively for institutional use. By the extra care employed in selecting and seasoning hardwoods, forming posts, legs, bed stretchers and other vital parts from solid stock, and fitting joints securely, Carrom gives you institutional furniture unequalled for serviceability.

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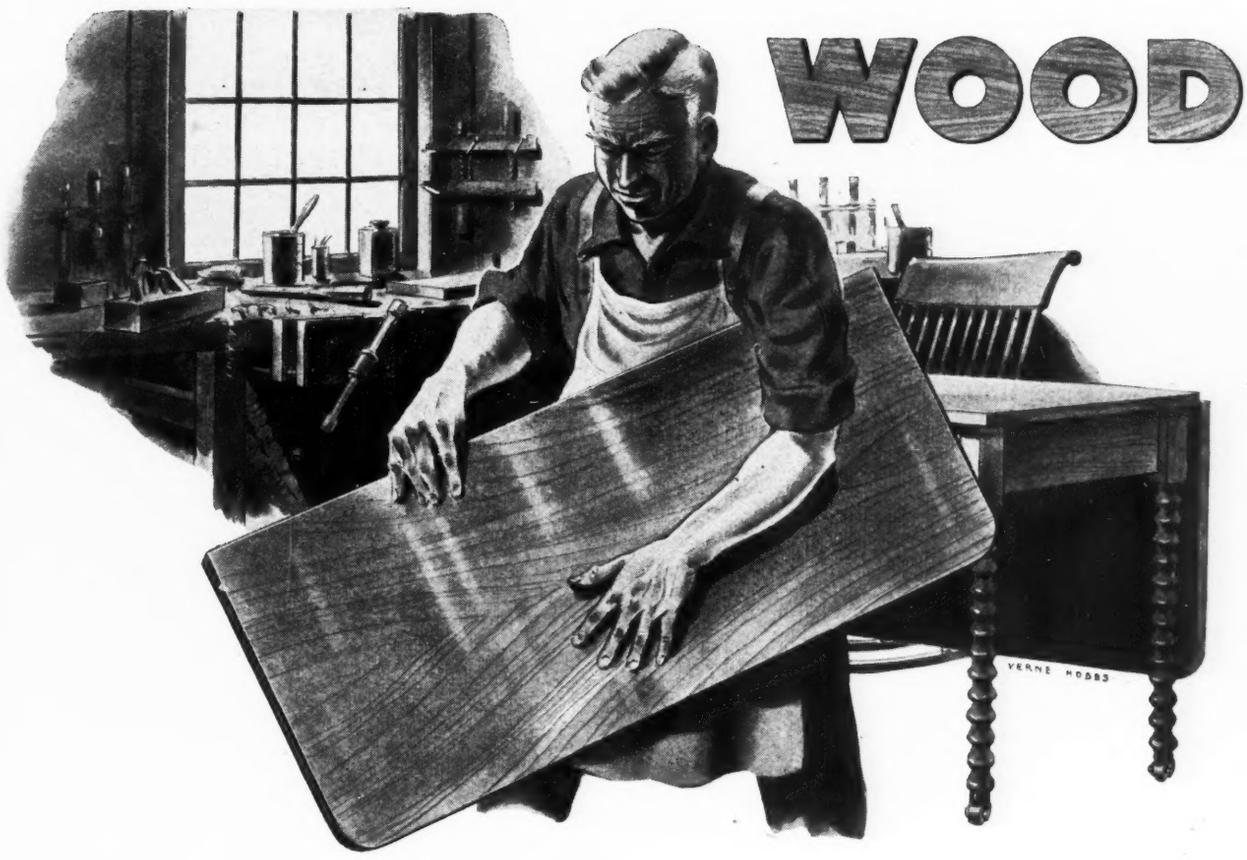

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WOOD FURNITURE FOR HOSPITAL SERVICE

43 States, Territories Designate Agencies for Hospital Survey Act

WASHINGTON, D. C.—Agencies to administer the Hospital Survey and Construction Act have been designated, either officially or tentatively, by 43 states and territories.

Communities, hospitals and professional groups that wish to participate in the program should direct their inquiries to the appropriate state or territorial agency named in the following list:

Alabama—No agency has been designated.
Alaska—Territorial Department of Health, Juneau. Dr. C. Earl Albrecht, Commissioner of Health.
Arizona—State Department of Health, Phoenix. Dr. G. F. Manning, Supt. of Public Health.
Arkansas—State Board of Health, Little Rock. Dr. T. T. Ross, State Health Officer.
California—State Department of Public Health, San Francisco. Dr. Wilton L. Halverson, Director of Public Health.
Colorado—No agency has been designated.
Connecticut—State Department of Health, Hartford. Dr. Stanley H. Osborn, Commissioner of Health.
Delaware—No agency has been designated.
District of Columbia—D. C. Health Department, Washington, D. C. Dr. George C. Ruhland, District Health Officer.
Florida—Florida State Improvement Commission, City Administration Building, Tallahassee. C. H. Overman, Director.
Georgia—Gerogia Department of Public Health, Atlanta. Dr. T. F. Abercrombie, Director of Public Health.
Hawaii—Territorial Board of Health, Honolulu. Dr. C. L. Wilbar Jr., President of Board of Health.
Idaho—Idaho Department of Public Health, Boise. L. J. Peterson, Acting Administrative Director.
Illinois—State Department of Public Health, Springfield. Dr. Roland H. Cross, Director of Public Health.
Indiana—State Board of Health, Indianapolis. Dr. Lee E. Burney, State Health Commissioner.
Iowa—State Department of Health, Des Moines. Dr. Walter L. Bierring, State Commissioner of Health.
Kansas—State Board of Health, Topeka. Dr. F. C. Beelman, Secretary and Executive Officer.
Kentucky—State Department of Health, Louisville. Dr. P. E. Blackerby, State Health Commissioner.
Louisiana—Health and Hospital Division of the Governor, Baton Rouge. Charles Mitchell, Director.
Maine—Department of Health and Welfare, State Bureau of Health, Augusta. Dr. Leverett D. Bristol, Commissioner of Health and Welfare.
Maryland—Maryland State Planning Commission, 104 Equitable Building, Baltimore. I. Alvin Pasarew, Director; Henry P. Irr, Chairman.
Massachusetts—Massachusetts Department of Public Health, Boston. Dr. Vlado A. Getting, Commissioner of Public Health.
Michigan—No agency designated.
Minnesota—Minnesota Department of Health, St. Paul. Dr. A. J. Chesley, Secretary and Executive Officer.
Mississippi—Mississippi Commission on Hospital Care, 207 Tower Building, Jackson. Dr. D. V. Galloway, Executive Director.
Missouri—State Division of Health, Bureau of Public Health and Welfare. Dr. R. M. James, Director, State Division of Health.
Montana—No agency designated.
Nebraska—Nebraska Department of Health, Lincoln. Dr. W. S. Petty, Director of Health.
Nevada—State Department of Health, Carson City. Dr. Fred S. Loe, State Health Officer.
New Hampshire—No agency designated.
New Jersey—New Jersey State Department of Institutions and Agencies, Trenton. Sanford Bates, Commissioner.
New Mexico—New Mexico Department of Public Health, Santa Fe. Dr. James R. Scott, Director of Health.
New York—New York State Postwar Public Works Planning Commission, New York. John E. Burton, Chairman.
North Carolina—North Carolina Medical Care Commission, P. O. Box 1880, 613-615 Commercial Bldg., Raleigh. James H. Clark, Chairman.
North Dakota—State Department of Health, Bismarck. Dr. William M. Smith, Acting State Health Officer.
Ohio—Ohio Department of Health, Columbus. Dr. Roger E. Heering, State Director of Health.
Oklahoma—State Health Department, 3400 North Eastern, Oklahoma City. Dr. Grady F. Mathews, Commissioner of Health.
Oregon—State Board of Health, Portland. Dr. Harold M. Erickson, State Health Officer.
Pennsylvania—State Department of Welfare, Harrisburg. S. M. R. O'Hara, Secretary of Welfare.
Puerto Rico—Department of Health, San Juan. Dr. Juan A. Pons, Commissioner of Health.
Rhode Island—No agency designated.
South Carolina—State Research, Planning and Development Board, Columbus. Robert M. Cooper, Director.
South Dakota—State Board of Health, Pierre. Dr. Gilbert Cottam, Superintendent of State Board of Health.
Tennessee—Tennessee Department of Public Health, Nashville. Dr. R. H. Hutcheson, Commissioner of Public Health.
Texas—State Department of Health, Austin. Dr. George W. Cox, State Health Officer.
Utah—State Department of Health, Salt Lake City. Dr. Wm. M. McKay, State Health Commissioner.
Vermont—No agency has been designated.
Virginia—Virginia Department of Health, Richmond. Dr. L. J. Roper, State Health Commissioner.
Washington—State Department of Health, Seattle. Dr. Arthur L. Ringle, State Director of Health.
West Virginia—State Department of Health, Charleston. Dr. N. H. Dyer, State Health Commissioner.
Wisconsin—State Board of Health, Madison. Dr. Carl N. Neupert, State Health Officer.
Wyoming—No agency has been designated.

Radiologists to Meet

Radiologists will meet in Chicago February 8 for their fourteenth annual conference of teachers of clinical radiology, according to an announcement released by the American College of Radiology. The conference will precede the A.M.A. Congress on Medical Education and Licensure.

Hospital Changes Name

Berkeley Hospital, Berkeley, Calif., has changed its name to Herrick Memorial Hospital in honor of Dr. LeRoy Francis Herrick, who founded the institution in 1904.

United Medical Service Increases Benefits Without Raising Price

The more than 325,000 members of United Medical Service of New York City will be granted increased benefits, including higher payments toward doctors' fees for surgical and maternity care, without increase in subscription costs for the coming year.

Under an agreement with physicians who participate in the medical service plan, all persons with a family income of $2500 or less per year are entitled to complete coverage for surgical care and treatment, including periods of aftercare.

The physicians, who have agreed to accept U.M.S. payments as full compensation for services to members in this income bracket, may, if they wish, make an additional charge to those with a higher family income. The aggregate increase in payments covering surgical care will amount to approximately 22 per cent, with indemnities ranging as high as $225, as against the present maximum of $150. Payments covering maternity care will be increased from $50 to $60.

Another increase in benefits announced by the plan in January is payment of $3 per visit toward a physician's fee for a maximum of two visits per day during the first three days of hospital care instead of the former allowance of $3 per day beginning with the fourth day. In addition, U.M.S. will grant members an allowance of $10 toward the consultation fee of a qualified specialist when requested by the attending physician. These new increases will be limited to medical cases in hospitals.

National Institute of Health Plans Expansion

WASHINGTON, D. C.—The U. S. Public Health Service plans to ask Congress next year for funds to establish a new medical research center as part of the National Institute of Health, Dr. E. E. Dyer, the institute's head, said in an interview. The center will include a 200 to 300 bed hospital for the clinical study and treatment of cancer patients and a section of the same size for the study of patients suffering from heart ailments and the diseases of old age.

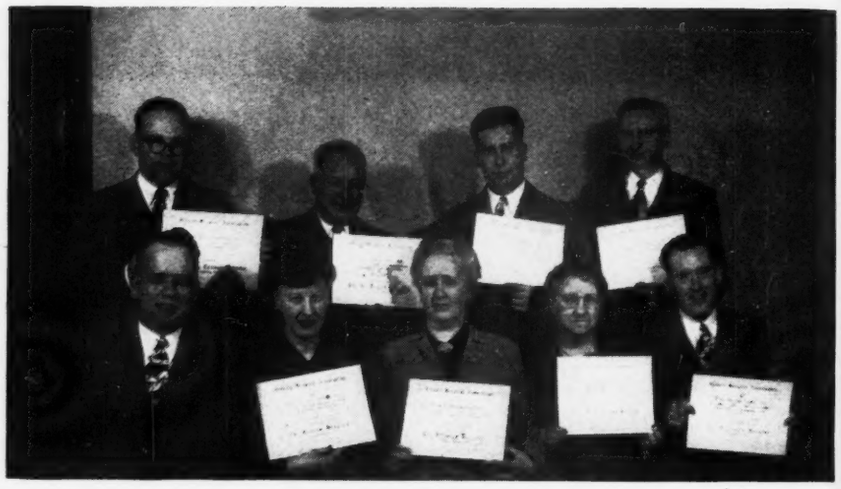
Dr. Dyer also confirmed reports that additional funds will be asked for the expansion of clinical and laboratory research. With such help, treatment and research can be conducted at the same place, thus giving better results. The new center would be a unique general hospital with research as its primary function.

Don't Count Too Much on Federal Funds, Illinois Group Warned

Hospital administrators in Illinois were warned against assuming that federal funds would be available for every hospital construction project by Rev. John W. Barrett of Chicago, chairman of the committee on government relations of the Illinois Hospital Association. Speaking at a business meeting of the association in Springfield last month, Father Barrett pointed out that the limited amount of federal funds would restrict federal aid to only the most badly needed hospital projects.

Following Father Barrett's talk, members of the association discussed the drafting of hospital licensing legislation for the state in line with new federal requirements. Everett W. Jones, vice president of The Modern Hospital Publishing Company, urged the association to make certain that a qualified hospital architect be appointed to the state advisory hospital council, and Stuart K. Hummel of Joliet urged that this council be given specific legal power as well as an advisory function in the proposed legislation.

After lengthy discussion, the association voted not to support the proposed revision to the Nurse Practice Act in Illinois, which would require licensing of practical as well as graduate nurses. The revision was sponsored by the Illinois Nurses' Association. During the discussion, Dr. Hugo Hullerman of the American Hospital Association warned that any legislation calling for the licensing of all persons engaged in nursing for hire should be examined carefully from all angles. He pointed out the importance of exempting from any such licensing legislation hospital practical nurses or nurse's aids who give some patient care under the supervision of nurses. Mr. Hummel added that under present nurse shortage conditions hospitals should hesitate to pass any law which might further restrict the number of persons available to perform necessary nursing functions.

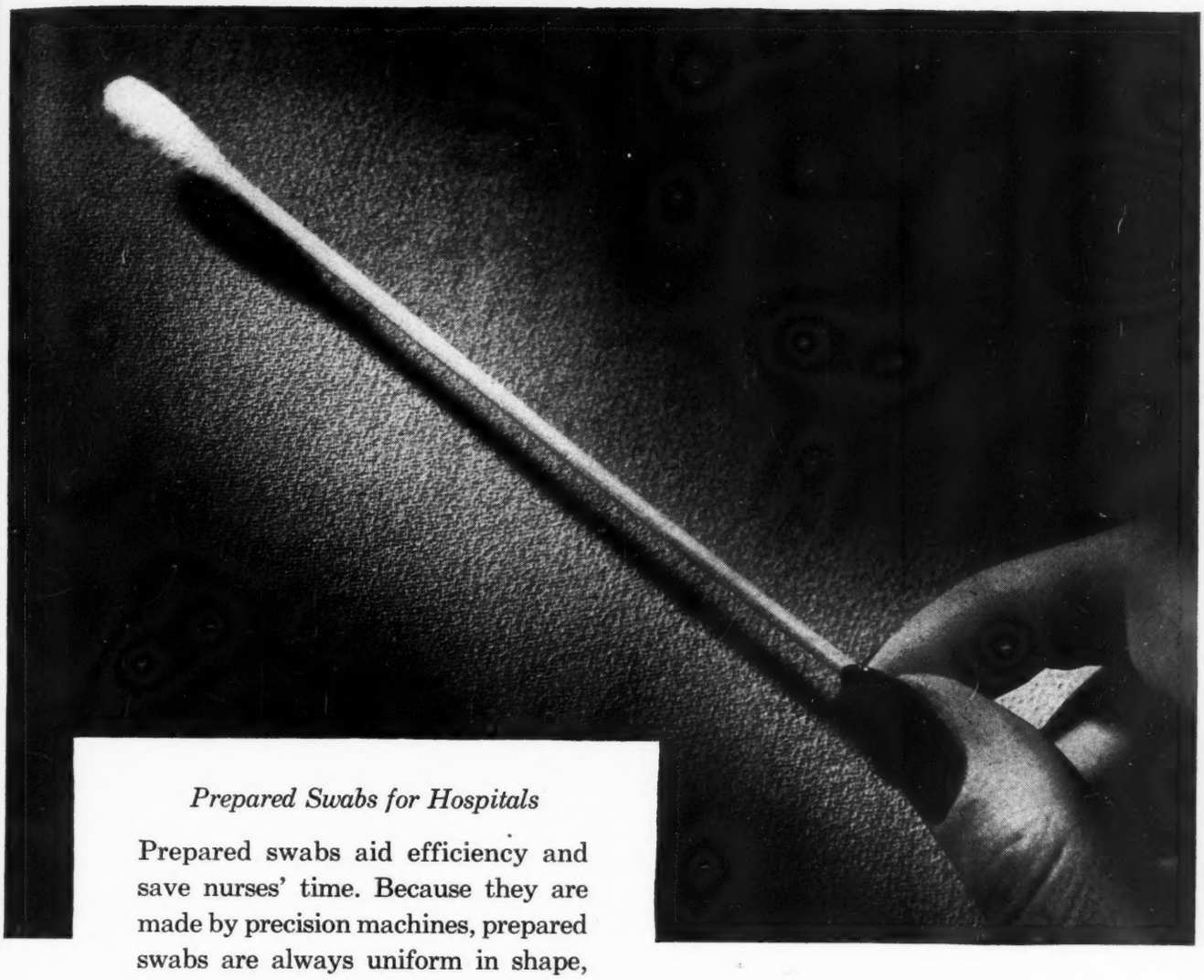


I.H.A. public education award winners are: Front row, left to right: C. Norman Andrews who presented the awards; Evelyn G. Johnson, Brokaw Hospital, Bloomington-Normal; Myrtle McAhren, Blessing Hospital, Quincy; Mrs. Florence Slown Hyde, Silver Cross Hospital, Joliet; Harry D. Keller, Deaconess Hospital, Freeport. Back row, left to right: Leon A. Bondi, Cottage Hospital, Galesburg; Leo M. Lyons, St. Luke's Hospital, Chicago; Richard Hocking, Grant Hospital, Chicago; N. O. Hoover, Bloomington-Normal Hospital Council, who accepted the certificate of merit for the "Daily Pentagraph" of Bloomington. The first place award in the daily newspaper class was accepted for the Joliet "Herald News" by Stuart K. Hummel, administrator of the Silver Cross Hospital, Joliet (not shown in the picture).

Dr. Henrietta Herbolsheimer, director of the state hospital survey for Illinois, reported that only five hospitals throughout the state refused to complete schedules of information called for by the state survey group.

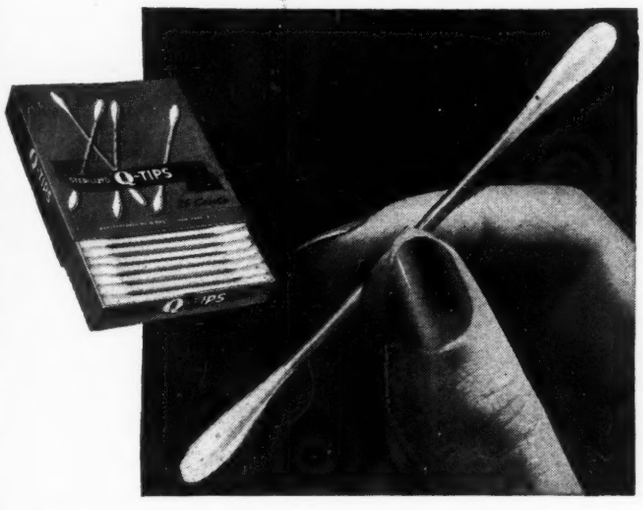
Raymond Hilliard, director of the Illinois Public Aid Commission, appealed for hospital support in obtaining a revision of the federal Social Security law which will permit payment direct to hospitals and clinics for public aid cases. Charles A. Lindquist, administrator of the Sherman Hospital, Elgin, Ill., and chairman of the Blue Cross council of the Illinois Hospital Association, discussed the proposed merger of Chicago and Peoria Blue Cross plans. The council presented a resolution recommending this merger as a step toward consolidation of all the Blue Cross plans into one statewide organization. After considerable discussion, a revised resolution recommending the principle of statewide Blue Cross unification but omitting specific mention of the proposed Chicago-Peoria merger was passed.

A citation for meritorious service was presented to J. W. Meyer, who retired recently as superintendent of the Copley Hospital at Aurora after thirty-seven years of service to the hospital.



Prepared Swabs for Hospitals

Prepared swabs aid efficiency and save nurses' time. Because they are made by precision machines, prepared swabs are always uniform in shape, size, weight and absorption rate. The cotton swab ends are firmly woven and securely fastened to the applicator sticks. For all these reasons, the use of ready prepared swabs is standard practice in leading hospitals.



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Crosby Heads Maryland Group for Coming Year

Through action taken at the sixth annual meeting of the Maryland-District of Columbia Hospital Association held in Washington, D. C., November 25-26, the legislature of Maryland was requested to transfer the responsibility for the disbursement of state funds to general hospitals now resting with the State Department of Public Welfare to the State Board of Health. It was also urged that payments to hospitals for in-patient hospital care rendered to eligible persons be based on a per patient per day basis not limited by an appropriation specifically allocated to individual hospitals. Finally, it was recommended that such per patient per day payments be a rate to approximate the actual hospital cost of rendering such service as now determined under the government's Emergency Maternity and Infant Care Program.

Despite the necessity of a postponement from the original date because of the Washington hotel strike, the attendance was good. Registration figures passed the 500 mark, including representatives from 51 member institutions. Business sessions and general meetings centered upon current problems with such speakers participating as John H. Hayes, president, American Hospital Association, and director, Lenox Hill Hospital, New York City; Lt. Col. Harry E. Brown, director, Medical Administration Service, Veterans Administration; Dr. V. M. Hoge, medical director, chief, division of hospital facilities, U. S. Public Health Service; Raymond P. Sloan, editor, The MODERN HOSPITAL, and Dr. G. Canby Robinson, executive secretary, Maryland Tuberculosis Association.

Caposella

Dr. Edwin L. Crosby, director, Johns Hopkins Hospital, Baltimore, becomes president for the new year. Other officers are president-elect, James G. Caposella, superintendent, Central Dispensary and Emergency Hospital, Washington; first vice president, Jane E. Nash, R.N., superintendent, the Church Home and Hospital, Baltimore; second vice president, Sister Vincent Marie, R.N., acting superintendent, Allegany Hospital of the Sisters of Charity, Cumberland; third vice president, Sister Marie, R.N., administrator, Providence Hospital, Washington, D. C.; secretary, Richard R. Griffith, administrator, West Baltimore General Hospital, Baltimore, and treasurer, William A. Dawson, director, South Baltimore General Hospital, Baltimore.

Record Attendance at Missouri Meeting; Lohr Takes Office

A state association that can attract 360 persons to its annual dinner—many of them trustees, medical society officers, clergymen and city and county officials—is on chummy terms with its preferred public.

The Missouri group did just that on the night after Thanksgiving, but then to the Missouri association the winning of national public relations awards is becoming habitual.

At this St. Louis gathering the Missouri Hospital Association voted to back up with cold cash its proposed area hospital councils which will stimulate hospital growth in small towns and rural sections. To implement this, the association voted substantial increases in dues. So determined is it to push through both its rural and its legislative programs that certain officers had actually talked of seceding from the A.H.A. in order to apply all state hospital funds to state needs. On the proposed rural hospital councils the country newspaper editor will occupy an important chair.

Dr. Herman Smith, consultant and former director of Chicago's Michael Reese, was the banquet speaker. He took a critical view of some of the findings of the Commission on Hospital Care and some of the recommendations of the Michigan survey.

Graham Davis, A.H.A. president-elect, came to the meeting to tell of the progressive sweep of the Michigan survey, which, if acted upon, will reduce Detroit's 60 hospitals to 30 and will mean the closing of many nonmetropolitan small hospitals and the building of new health centers in remote areas.

The A.H.A.'s legislative program was presented crisply by Albert V. Whitehall; other importations included Robert G. O'Brien, opening civilian hospital vistas in the V.A. program; Jon M. Jonkel, bringing public relations coals to Newcastle, and Gordon H. Ambruster, talking on tests in selecting and placing personnel.

But Missouri's home talent held its own with the outsiders in progressive planning. Mention has already been made of the rural program; to this must be added Hal G. Perrin's contribution on merit rating and Clinton F. Smith's forthright talk on labor unions, based on ten years' experience with the largest labor group in any St. Louis hospital.

Harry J. Mohler up front and Irene F. McCabe behind the scenes ran the convention with authority and smooth dispatch.

Now Dr. Curtis H. Lohr of St. Louis County has taken over the reins for 1947 to be succeeded in 1948 by Edward A. Thomson of St. Joseph.

Other new officers and trustees elected are: first vice president, True Taylor of Bethesda Hospital, St. Louis; second vice president, R. J. Connor, Ellis Fischel Hospital, Columbia; treasurer, Rev. E. C. Hofius, Lutheran Hospital, St. Louis; trustees, C. J. Heasel, St. Louis; Herbert S. Wright, Cape Girardeau, and Dr. Maynard W. Martin, St. Louis.

Selects Chicago Site for V.A. Hospital

A site for the 1000 bed veterans' hospital to be built in Chicago's west side medical center has been selected by a special committee, subject to approval by Gen. Omar Bradley. The 13 acre tract is in the center of the west side medical development near Cook County Hospital, University of Illinois and Loyola University medical schools.

Selection of the location was motivated by the V.A. policy of placing hospitals close to teaching and medical center facilities wherever possible, C. T. Thomason, a member of the selection committee, stated.

The complete medical center program will include $250,000,000 of research, educational and therapeutic facilities.

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The complete medical center program will include $250,000,000 of research, educational and therapeutic facilities.

Schedule Examinations for Appointment to U.S.P.H.S. Nurse Corps

WASHINGTON, D. C. — Examinations for the appointment of registered nurses to the first three grades of the regular commissioned corps of the U. S. Public Health Service will be given during February and March in 21 cities. Positions are open in Marine Hospitals for nurses in the grades of junior assistant nurse officer (comparable to the rank of army second lieutenant); assistant nurse officer (first lieutenant), and senior assistant nurse officer (captain).

Dates and places of the oral examinations are listed below. Written examinations will be held April 14 and 15 in designated places which will be announced at the time of oral examinations.

Place	*Date*
Atlanta, Emory University	March 13
Boston, Marine Hospital	February 24
Chicago, Marine Hospital	March 6-7
Cleveland, Marine Hospital	March 4
Denver, District Office, 617 Colorado Building	March 28
Detroit, Marine Hospital	March 5
Galveston, Tex., Marine Hospital	March 18
Kansas City, Mo., District Office, 200 Mutual Building	March 31
Los Angeles, Relief Station, 406 Federal Building	March 20-21
Minneapolis, University of Minnesota	March 10
Nashville, Vanderbilt University	March 12
New Orleans, Marine Hospital	March 17
New York, Relief Station, 67 Hudson Street	February 25-26
Pittsburgh, Marine Hospital	March 3
Portland, Ore., Marine Hospital	March 25
Rochester, N. Y., University of Rochester	February 28
San Francisco, Marine Hospital	March 24
Seattle, Marine Hospital	March 26
St. Louis, Kirkwood Marine Hospital	March 11
Syracuse, N. Y., University of Syracuse	February 27
Washington, D. C., U.S.P.H.S. Dispensary, Fourth and D Streets, S. W.	April 7

Candidates for the three grades will be judged on the basis of personal, professional and physical fitness. Positions are also open for nurses in public health nursing and for certain special projects of the Public Health Service. Qualifications for the regular commissioned corps are as follows:

Junior Assistant Nurse Officer: Any registered nurse, at least 18 years of age and a citizen of the United States, who has a diploma from a state accredited school of nursing connected with a hospital maintaining a daily average census of not less than 50 patients and offering experience in medicine, surgery, pediatrics and obstetrics. She must have been graduated from an accredited high school or possess equivalent college entrance requirements. Senior students may take the examination if, upon graduation and registration, they fill these requirements.

Assistant Nurse Officer: Candidates must have been out of high school for at least seven years (with intervening time devoted to educational and professional training) and must hold an academic degree or have served at least four years in either the U.S.P.H.S., the army or navy nurse corps.

Senior Assistant Nurse Officer: Candidates must have completed at least four additional years of postgraduate training or experience, or a total of eleven years since graduation.

British M.D.'s Oppose National Health Plan

A majority of physicians in Great Britain voted against cooperating with the government's national health service plan, the British Medical Association revealed last month in announcing the results of a poll of its membership. Minister of Health Aneurin Bevan declared that he will go forward with the program, which has been approved by the House of Commons, in spite of medical opposition.

Asked whether they believed doctors should enter into negotiations with the government looking toward effecting the government health scheme, 23,110 British Medical Association members said "No," and 18,972 members answered "Yes."

Weiskotten Heads A.M.A. Council on Medical Education and Hospitals

Dr. Herman G. Weiskotten, professor of pathology and dean of the college of medicine at Syracuse University, has been elected chairman of the Council on Medical Education and Hospitals of the American Medical Association, succeeding Dr. Ray Lyman Wilbur of Leland Stanford University. Doctor Weiskotten directed the council's survey of medical education in the United States in 1935 and 1936 and served as secretary of the council for a year prior to the appointment of Dr. Victor Johnson to that position.

"The council now faces great responsibilities in the reconversion of medical education, the improvement of hospital internships and residencies, the almost overwhelming task of meeting the educational desires of physician veterans and other equally important problems," the *Journal of the American Medical Association* stated, commenting on Doctor Weiskotten's election.

The annual A.M.A. Congress on Medical Education and Licensure will be held at the Palmer House in Chicago February 10 and 11.

New England Assembly to Feature One Day Institute for Trustees

A day long institute for hospital trustees will be a new feature of the 1947 New England Hospital Assembly to be held in Boston the week of March 24, Paul J. Spencer of Lowell General Hospital, Lowell, Mass., secretary of the assembly, has announced.

"We hope to have several hundred trustees from the various New England hospitals in attendance," Mr. Spencer said. "This is the first time we have sponsored a trustee institute of this kind."

The assembly, which will cover every phase of hospital operation in a three day program of meetings, conferences and discussion groups, has increased the number of its sections from 14 to 20, Mr. Spencer said.

"We expect that our registration will beat last year's 2300 by a wide margin," he added.

COMING MEETINGS

ALABAMA HOSPITAL ASSOCIATION, Jefferson Davis Hotel, Montgomery, March 14-15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Educational Conference, Stevens Hotel, Chicago, Feb. 17-21.

AMERICAN COLLEGE OF SURGEONS, Sectional Meetings: Providence, R. I., March 6-7; Baltimore, March 10-11; Atlanta, March 14-15; Fort Worth, March 20-21; Omaha, April 7-8; Winnipeg, Man., April 14-15; Vancouver, B. C., April 21-22; San Francisco, April 28-29.

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference for Presidents and Secretaries, Drake Hotel, Feb. 7-8.

ARKANSAS HOSPITAL ASSOCIATION, Little Rock, May 15-16.

ASSOCIATION OF CALIFORNIA HOSPITALS, Recreation Center, Santa Barbara, Feb. 12-13.

ASSOCIATION OF WESTERN HOSPITALS, Seattle, Wash., May 12-15.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke, Va., April 2-4.

CATHOLIC HOSPITAL ASSOCIATION, Mechanics Hall, Boston, June 16-20.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Buffalo, May 21-23.

IOWA HOSPITAL ASSOCIATION, Des Moines, April 20-23.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, March 27-28.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 23-25.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 12-13.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

NEW JERSEY HOSPITAL ASSOCIATION, Dennis Hotel, Atlantic City, May 15-17.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 8-10.

PENNSYLVANIA HOSPITAL ASSOCIATION, Pittsburgh, April 23-25.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Buena Vista, Biloxi, Miss., April 10-12.

TEXAS HOSPITAL ASSOCIATION, Rice Hotel, Houston, March 27-29.

WASHINGTON STATE HOSPITAL ASSOCIATION, Seattle, May 11-15.

WISCONSIN HOSPITAL ASSOCIATON, Hotel Schroeder, Milwaukee, Feb. 20.

Plan Hospital and Research Center for Study of Spastics

The offer of a $500,000 estate of more than 50 acres to the University of Rochester School of Medicine and Dentistry will aid the university in its project of establishing a rehabilitation hospital for spastic children in cooperation with the New York State Health Department and the National Foundation for Infantile Paralysis.

The gift, from Mr. and Mrs. Ernest L. Woodward of LeRoy, N. Y., comes at an opportune time in relation to a five year program started by the university under a $292,000 grant in aid made last July by the National Foundation for Infantile Paralysis for basic research in both cerebral palsy and infantile paralysis.

The estate includes a spacious residence that can readily be adapted to use as a hospital facility. Plans call for a thorough-going, long term program of diagnosis, research, treatment and aftercare to be directed by the university and its Strong Memorial Hospital, of which Dr. Basil C. MacLean is director.

Gov. Thomas E. Dewey has included in his 1947 budget message to the New York State Legislature an appropriation of $150,000 for the annual operating cost of the proposed clinic.

It is hoped that the LeRoy unit can be placed in operation by next summer.

California G.O.P. Opposes Warren Health Plan

California Republicans were reported as organizing opposition to Gov. Earl Warren's program for a state compulsory medical care plan, according to newspaper reports early in January. The governor told California legislators that he believed in the principle of state prepayment for medical care and intended to press enactment of his legislation. "I am hopeful that the people who have fought every effort to establish such a system will open their minds and attempt to find some way to do it," Governor Warren declared.

Immediately after hearing the Warren message, a Republican central committee in Sacramento County was reported to have adopted a resolution opposing "the socialization or regimentation of labor, industry, business or the professions." Legislative leaders in California gave the governor's program little chance of successful passage.

Higher Pay, Shorter Hours at New York Hospital

A schedule of higher pay and shorter hours for nurses was adopted last month by the New York Hospital. A 44 hour week will be introduced for students of the New York Hospital-Cornell University School of Nursing, beginning with the opening of the February school term, Murray Sargent, hospital director, said. Approximately 1000 members of the hospital staff benefited from the new schedules, which also affected supplementary nursing and dietary personnel.

"This step establishes the 44 hour week as the maximum work week in any department of the hospital, which is one of the first and surely the largest of the voluntary hospitals in this area to make such a sweeping revision in its wages and hours," Mr. Sargent stated.

New A.C.H.A. Regents

F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J.; E. I. Erickson, superintendent, Augustana Hospital, Chicago, and Dr. Curtis H. Lohr, superintendent, St. Louis County Hospital, Clayton, Mo., have been named regents of the American College of Hospital Administrators.

Formulate Plan for Uniform Intern Placement

A six point plan for uniform intern placement has been formulated and accepted by the Association of American Medical Colleges, the A.M.A. Council on Medical Education and Hospitals, the A.H.A. Council on Professional Practice, the Catholic Hospital Association and the American Protestant Hospital Association.

Details of the plan are as follows:

1. Letters of recommendation by faculty members as a hospital requirement should be eliminated, all information about applicants being centralized in the deans' offices and credentials sent out from there.

2. Hospitals are requested to eliminate the statement from the intern application blank that the student will agree to accept if appointed.

3. The date for filing applications and release of credentials by the medical schools has been set as Oct. 15, 1947, for internships beginning July 1, 1948.

4. Appointment date by hospitals shall not be before November 15.

5. There shall be no specific waiting period following announcement of appointments. Hospitals will be requested to notify all applicants of acceptance, alternate position or rejection (with the understanding that notification of rejection may be made by the hospital at any time).

6. Notification is to be sent to the hospitals that it is anticipated that dates for filing release of information and appointment will be moved farther into the senior year in 1949 for internships beginning in that year.

V.A. Advisory Group Meets

WASHINGTON, D. C.—Set for January 21 and 22 was the first regular meeting of the new advisory group on the over-all medical care for veterans recently appointed by the Veterans Administration. This committee, whose chairman is Dr. Charles W. Mayo of the Mayo Clinic, consists of 19 doctors, nurses, social service workers and dietitians whose names are nationally recognized. They will act in an advisory capacity to Gen. Omar N. Bradley and Dr. Paul R. Hawley.

A.C.H.A. Plans Conference

An educational conference, with attendance limited to members only, will be conducted by the American College of Hospital Administrators February 17 to 21 in the Stevens Hotel, Chicago. Current problems relating to patient protection, nursing service and employe relationships will be discussed. Experienced lecturers and consultants in the hospital field will present the program in which the Joint Commission on Education, headed by Charles E. Prall, will cooperate.

Wyoming Joins Mid-West

Affiliation of the Wyoming Hospital Association with the Mid-West Hospital Association has been announced. Wyoming is the first new state association to become a member of the Mid-West since the Nebraska Hospital Assembly joined in 1940. The Mid-West group is now comprised of seven state associations: Arkansas, Kansas, Missouri, Colorado, Oklahoma, Nebraska, Wyoming.

Cancer Nursing Course

Beginning in February, the division of nursing education of Teachers College, Columbia University, will conduct a course devoted exclusively to cancer nursing, including aspects of cancer treatment, prevention, research and education. The university will work in close cooperation with Memorial Hospital for the Treatment of Cancer and Allied Diseases, which is making available generous scholarships and fellowships for qualified nurses.

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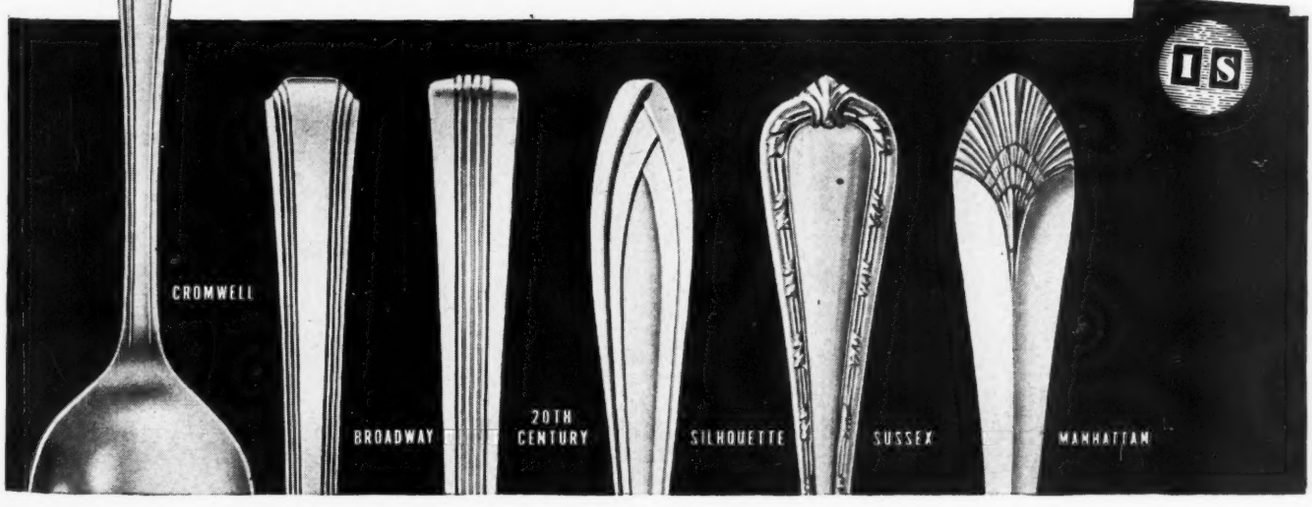


A.M.A. Approves Hiring of Public Relations Aid

Meeting in Chicago the week of December 9, the House of Delegates of the American Medical Association approved employment of a public relations assistant and an economist as members of the association's headquarters staff. The new staff members will effect a public relations program recommended for the association by Raymond Rich Associates, New York public relations counsel.

In addition to the recommendation establishing a public relations office, the Rich organization's report is said to have urged the A.M.A. to discontinue its support of the National Physicians Committee for the Extenson of Medical Service.

Reporting to the House of Delegates on health conditions in the nation's mining regions, R. Adm. Joel T. Boone declared that medical care in these areas was often found inadequate, especially in preventive measures. "I have been disappointed to learn that except for school health programs of immunization, physicians have evidenced very little interest in public health and preventive medicine," he declared.

Seek $4,200,000 for Nursing Costs

A budget calling for increases in nursing salaries and substantial additions to the staff of Cook County Hospital Nurses' Home, Chicago, was presented to the county board of commissioners last month. The nursing home cost the hospital $2,700,000 in 1946, it was reported, and the 1947 budget calls for expenditures totaling $4,200,000.

Among the recommended increases were $200,000 for sick pay and vacations for employes, $200,000 for a retirement plan and $150,000 representing the cost of changing from a 48 to a 44 hour week.

The nurses' home is a nonprofit corporation which furnishes nurses for the Cook County Hospital and conducts a school of nursing education.

Warns of Hazards of Prolonged Bed Rest

The hazards of prolonged bed rest for surgical patients were emphasized by Dr. Howard A. Rusk of New York at the thirty-ninth annual Clinical Congress of the American College of Surgeons in Cleveland last month.

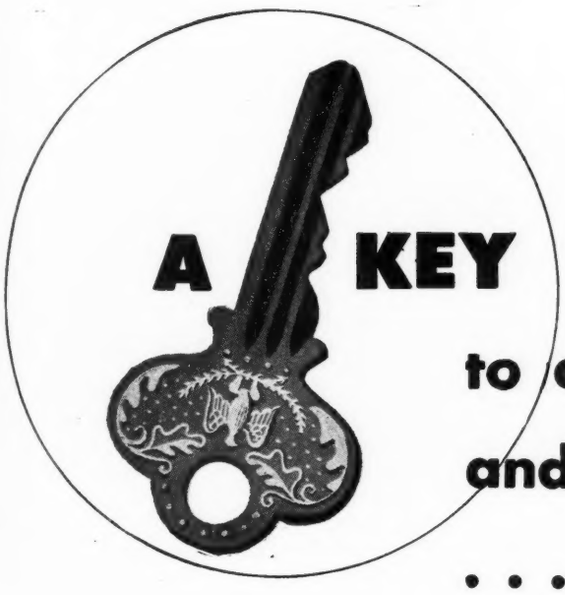
Actually, "bed is a dangerous place," Dr. Rusk reported, indicating that prolonged bed rest deconditioned surgical patients and urging surgeons to get as many patients as possible out of bed on the day of operation or the day after.

Reporting on the condition of patients who remained in bed for a number of weeks following surgery, Dr. Rusk said that studies made at Cornell University and the University of Minnesota medical schools showed a marked decrease in the size of the patient's heart, an increase in pulse rate, inability to do sustained work, reduced basal metabolic rates, increased excretion rates for thiamin and riboflavin and increased susceptibility to fainting.

Dr. Rusk reported that a group of orthopedic patients under a program of regular exercise showed no muscular atrophy following the removal of casts and returned to normal routines in half the time taken to complete the cure for nonexercising patients.

Curb Enrolls in Blue Cross

Hospitalization and surgical coverage have been arranged by the New York Curb Exchange for its 25 employes and their family dependents through Associated Hospital Service of New York and United Medical Service. The company will pay the entire cost of both services.



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A.H.A. Announces List of Institutes for 1947

Approximately 30 institutes covering the work of various departments of the hospital are to be conducted by the American Hospital Association, in cooperation with several organizations, within the next few months.

The schedule of the institutes now planned is as follows:

February 10-14: Institute on Purchasing, Drake Hotel, Chicago.

March 17-21: Institute for Medical Record Librarians, Benjamin Franklin Hotel, Philadelphia, in cooperation with the American Association of Medical Record Librarians.

March 24-28: Institute for Accounting Executives, New York City, in cooperation with the United Hospital Fund of New York.

April 14-18: Institute on Basic Accounting and Business Office Procedures, Chicago.

May 26-30: Institute for Nurse Anesthetists, New Orleans, in cooperation with the American Association of Nurse Anesthetists.

June 9-13: Institute for Medical Record Librarians, Denver, in cooperation with the American Association of Medical Record Librarians.

In addition, two institutes for dietitians are planned tentatively for June and three or four institutes for personnel officers are being worked out.

Children's Hospital Plans Medical Center

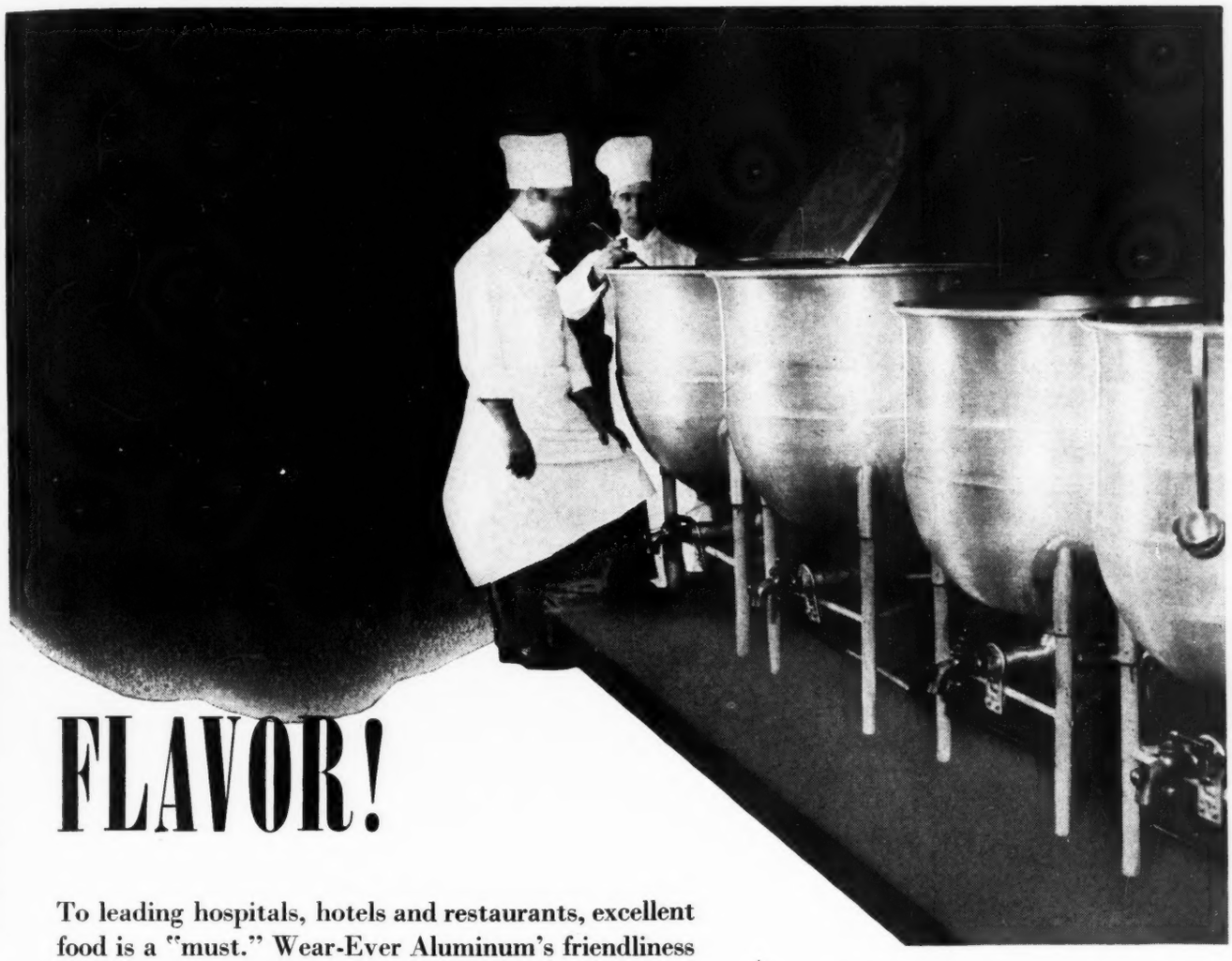
A nationwide campaign for $10,000,000 will be launched in April by Children's Hospital in Boston for the erection of a medical center for children that will be comparable to Mayo Clinic for adults.

The famed 77 year old institution has been forced to reject 99 out of 100 applicants for internship because of limited facilities. The hospital's trustees hope the new center, which is planned for completion in the next five years, will partly solve that problem.

In the last six years patients have come to Children's Hospital from 37 states and 23 foreign countries.

Fund Distributes $4,209,619

The Greater New York Fund this year increased its annual distribution of funds to 415 New York health and welfare agencies by disbursing a total of $4,209,619, as contrasted with $3,895,630 in 1945. Gifts to the fund's annual campaign were received from some 26,000 business concerns and employe groups, including many unions, compared with 22,875 for 1945.



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Aluminum

Pharmacists Hold Atomic Energy Forum

New tools for basic research in many fields of medicine were described by Dr. Frank H. Krusen of the Mayo Clinic in a paper on the medical aspects of atomic energy delivered at the mid-year meeting of the American Pharmaceutical Manufacturers' Association in New York last month. Dr. Krusen's paper was one of several given in an atomic energy forum which was a feature of the meeting.

So far the most successful therapeutic applications of atomic energy have been the treatment of polycythemia with radioactive phosphorus and the use of radioactive iodine in the diagnosis and treatment of thyroid disease, Dr. Krusen said. He also described uses of radioactive substances as aids in medical research.

Other scientific authorities addressed the meeting on recent progress in fungus diseases, Rickettsial diseases, hormone therapy and use of antibiotics.

New Blue Cross Quarterly

Made available through the Blue Cross Commission's office, approximately 72,000 copies of *Blue Print for Health*, the commission's new quarterly publication describing activities in the Blue Cross field, were distributed by various Blue Cross plans as part of their local public relations program. "The principal aims of this new house organ include the dissemination of health education on a popular level and the stimulation of interest in Blue Cross plans," an announcement from the commission's office said.

Hotel Man to Head Cook County Hospital

Fred A. Hertwig has been appointed warden of Cook County Hospital, Chicago, succeeding General Manus McCloskey. Mr. Hertwig, who was appointed by William N. Erickson, president of the Cook County Board of Commissioners, was formerly manager of the Georgian Hotel, Evanston, Ill. He is a construction engineer who has supervised the building of several Chicago office buildings.

Mr. Hertwig's appointment to the important Cook County position without previous training in hospital administration was publicly deplored by Dr. Malcolm T. MacEachern of the American College of Surgeons; Dr. William F. Petersen of the Chicago Institute of Medicine; Dr. Morris Fishbein of the American Medical Association and E. E. Salisbury of the Chicago Hospital Council. Replying to these critics, Mr. Erickson stated that his appointee possessed "a unique combination of qualities" for the job. "Hertwig will approach the problems ahead of him with the viewpoint of a hotel man," said Mr. Erickson.

Conclude $1,000,000 Campaign

A successful campaign for $1,000,000 to be used for much needed expansion of facilities has been concluded by Maryland General Hospital, Baltimore. Through the activities of more than 800 volunteers, well over 10,000 subscriptions were realized. Members of the medical staff set a high standard of giving in subscribing $250,000, and they also worked as members of the special gifts committee.

Add to St. Clare's Hospital

Construction has begun on a six story addition to St. Clare's General Hospital in New York City, with completion scheduled for the end of 1947. The new structure, which is estimated to cost approximately $1,000,000, will be the third addition to St. Clare's since it was taken over in 1934 by the Sisters of the Third Order Regular of St. Francis and will bring the total bed capacity to 421.

100 Record Librarians Attend Dallas Institute

More than 100 medical record librarians and hospital administrators attended an institute sponsored by the American Hospital Association and the American Association of Medical Record Librarians in Dallas, last month. The institute was one of a series being conducted jointly by the two groups to offer basic training in the medical record field for hospital employes.

Morning and afternoon lectures and demonstrations were devoted to various aspects of medical record work throughout the four day institute. Evening discussion sessions were led by recognized authorities in the hospital and medical record fields.

Another of these institutes aimed at combating the shortage of trained medical record librarians will be held in Philadelphia early this spring.

Operating Costs Rise

Costs of operation of Massachusetts hospitals have increased from 25 to 100 per cent since 1940, a survey made by the Massachusetts Blue Cross has revealed. The survey covered 151 member institutions. "Eventually we will be forced to increase subscription rates in order to offset the rising hospital costs," George C. Melville, Massachusetts Blue Cross director of hospital relations, said when results of the survey were announced.

ABOUT PEOPLE

(*Continued From Page* 84.)

ceeding **Mrs. T. M. McInnerney,** who has retired after sixteen years of service. Dr. Smith, who served in the army medical department, was hospital consultant to the prefectural government in Japan and supervised building of four hospitals in Japan for the army of occupation. Prior to his army service he served as administrator of Memorial Hospital at Manchester, Conn., and of Elm Terrace Hospital, Lansdale, Pa.

Herman J. Grimmer Jr., specialist in hospital administration for the Institute of Inter-American Affairs in Ecuador, has been decorated by the Ecuadorian government in recognition of his contribution during the last four years to the institute's division of health and sanitation.

Mr. Grimmer, who has contributed articles to The MODERN HOSPITAL, is administrator of the Guayaquil General Hospital, a 700 bed institution in Guayaquil, Ecuador. He is also a consultant for the board of welfare, the anti-tuberculosis league and other health organizations throughout the republic.

A. D. Kincaid Jr. has left his position as administrator of City Memorial Hospital, Winston-Salem, N. C., to join the consulting staff of James A. Hamilton and Associates. Another new member of the Hamilton staff is **R. J. Stull,** at present consultant in hospital administration to the Bureau of Hospital Surveys, California Department of Health, who will become western representative in February.

Department Heads

Howard King has joined the staff of Seaside Memorial Hospital, Long Beach, Calif., as public relations director. For the last ten years Mr. King has been executive secretary of the Long Beach Community Chest.

Edna E. Sharritt, R.N., has been appointed director of nursing and principal of the school of nursing at Toledo Hospital, Toledo, Ohio. Miss Sharritt was assistant director of nursing at the hospital from 1939 to 1942 when she resigned to enter the army nurse corps. She served as chief nurse in the corps for thirty-eight months. Miss Sharritt, a graduate of Grant Hospital School of

Nursing, Columbus, Ohio, received her B.S. degree from Columbia University and will receive her M.A. from the same institution this month.

Lennon R. Chapman has assumed the duties of chief accountant at Rochester General Hospital, Rochester, N. Y., succeeding **Robert H. Reeves,** whose resignation was reported last month. Mr. Chapman was formerly auditor of the Security Trust Bank in Rochester.

Etta Lubberts, R.N., formerly director of nurses at Methodist Hospital, Omaha, Neb., is now head of the nursing department at Ancker Hospital, St. Paul.

Hazel V. Doane has assumed the duties of public relations director of the Nebraska Blue Cross and Nebraska Medical Service associations at Omaha.

Glen E. Clasen assumed the position of controller of the University of Iowa Hospitals, Iowa City, on January 20. Mr. Clasen began his career in hospital administration in the business office of the Children's Hospital at Columbia-Presbyterian Medical Center, New York City, a position which he left to join the staff of the University Hospitals of Cleveland, where he served in various administrative capacities for ten years. In 1944 Mr. Clasen entered the navy as a lieutenant in the supply corps. Since his release from the navy in 1946 he served as a consultant in a study of the Cleveland Hospital Service Association and later on the staff of James A. Hamilton and Associates.

Edward Brodsky has resigned his position as comptroller of Beth Israel Hospital, Boston, to open an office in the Little Building, Boston, as accounting consultant serving the hospital field.

Lois B. Corder, director of nursing service and the school of nursing at the University of Iowa Hospitals, has accepted the position of superintendent of nurses at Santa Fe Coast Lines Hospital, Los Angeles. Miss Corder, a graduate of the university's school of nursing, returned to the hospital as assistant director of nursing in 1922. She became director of the hospital nursing service and of the school in 1927.

E. Louise Grant, former director of nursing service of the Hospital Division of the Medical College of Virginia, has accepted the position of principal of the school of nursing and director of the nursing service at Methodist Hospital, Indianapolis. She succeeds **Hazel Whittern.**

James E. Hague has been appointed director of public relations at Johns Hopkins Hospital, Baltimore.

Trustees

Louis C. Gerry has been elected president of Rhode Island Hospital, Providence, R. I., succeeding **Harris N. Bucklin,** who retired after seven years of service as president. Mr. Bucklin will continue to serve as a member of the board. Other new officers of the hospital board are: treasurer, **William Gammell Jr.,** and secretary, **Kenneth Shaw Safe.**

Miscellaneous

Florence Spaulding Marshall, R.N., director of nursing in the American Red Cross eastern area office, was appointed deputy administrator of the American National Red Cross Nursing Services on December 1.

Acme Photo

R. Adm. Clifford T. Swanson has been appointed surgeon general of the U. S. Navy and chief of the navy's bureau of medicine and surgery. Admiral Swanson was appointed by President Truman to succeed **V. Adm. Ross T. McIntire,** who has

retired after serving as surgeon general since December 1938.

Richard M. Jones, public relations director of the Blue Cross Commission of the A.H.A., has been named acting director of the commission until a permanent successor to **C. Rufus Rorem** is named.

Antone G. Singsen has been appointed administrative assistant to the director of the Blue Cross Commission. He will be responsible for coordinating procedures in the Chicago headquarters office. Prior to the appointment, Mr. Singsen was assistant to the commission's public relations director. He has been associated with Blue Cross since 1939, having served the Rhode Island and Connecticut plans.

Lawrence C. Wells has joined the public relations staff of the Blue Cross Commission. Mr. Wells was a continuity writer, news commentator and commercial film script writer before entering the army. He served overseas for three years.

Deaths

Thomas F. Henley, administrator of Bishop Clarkson Hospital, Omaha, Neb., since May 1, died of a virus infection December 1.

Mary Beard, director of the American Red Cross nursing service from 1938 to 1944, died at the age of 70 after an illness of several weeks.

Dr. Marshall Davison, 50, head of University Hospital, Chicago, and former medical director of Cook County Hospital, died December 16. After his resignation as medical director of Cook County Hospital in 1943, Dr. Davison continued as chief of its surgical staff. He was also an associate professor of surgery at Northwestern University Medical School and professor of surgery at Cook County Graduate School of Medicine.

Wesley W. Sherman, superintendent of Naeve Hospital, Albert Lea, Minn., died December 2 after a brief illness. Mr. Sherman, who had recently taken office as president of the Minnesota Hospital Association, had completed one year of service at Naeve Hospital. Previously, he had administered the Itasca County Hospital at Grand Rapids, Minn.

Dr. Charles Edward Remy, well known hospital administrator and consultant, died early in December in Wesley Memorial Hospital. Interment was in Arlington National Cemetery. Dr. Remy began his career in hospital administration as clinical director and assistant superintendent at the State Hospital for the Insane, Yankton, S. D. In 1925 he became assistant superintendent at Michael Reese Hospital, Chicago, and in 1930 went to Minneapolis as head of Minneapolis General Hospital. After leaving that position, Dr. Remy became administrator of Knickerbocker Hospital, New York City, in 1938 and remained there until 1940, when he left the administration field to devote his full time to hospital consulting work.

Dr. Remy was a charter fellow of the American College of Hospital Administrators and a member of both the American Hospital Association and the American Protestant Hospital Association. He held the rank of lieutenant colonel in the army medical reserve corps and served in the hospital facilities section of the U. S. Public Health Service in 1943.

Details regarding the continuation of Hospital Consultants, of which Dr. Remy was director, will be announced in a later issue.

Dr. John H. Law, 37, director of the Grace Hospital, Detroit, died January 9. Dr. Law received his M.D. from the University of Michigan and served his internship and residency at Grace Hospital. He served as assistant physician at Eloise, Mich., for two years and returned to Grace Hospital as assistant director in 1937. He was named head of the hospital in 1944.

THE BOOKSHELF

HOSPITAL PLANNING, *By Charles Butler and Addison Erdman. New York: F. W. Dodge Corporation.* 1946. *Pp.* 236. *Cloth,* $15.

In this book, Erdman and Butler offer the first comprehensive volume on hospital planning since the publication in 1928 of Edward F. Stevens' "American Hospital of the Twentieth Century." Anyone who has a real interest in hospital planning and the philosophies connected with such planning will indeed profit greatly by studying this new book carefully. I believe that the handling of the mental hospital problem would have been more convincing and in keeping with modern thought if more emphasis had been placed on the provision of acute treatment facilities for mental cases in or directly connected with general hospitals. Plans and discussions of the plans of these units in general hospitals would have been of great value.

The authors wisely point out that in planning a hospital, a master or key plan to cover a long period of years should be developed in the very beginning so that as the institution grows and requires alterations and additions a logical pattern can be followed.

It would be well if every person who has any connection with hospital planning could have the following statement from the book indelibly stamped upon his mind. "As it is built primarily for use, a plan must be worked out first of all to satisfy the needs set forth in the hospital program. Therefore, the best procedure for the architect is to make his plan first and then put on that plan the best elevation he can design without sacrificing essential functions."

In connection with the plans and comments on the administrative department, the architects might well have emphasized the importance, when the size of the hospital warrants such offices, of providing private offices for the assistant administrator, credit manager and assistant directors of nursing.

In discussing medical record rooms, it doesn't seem as though the authors have placed enough emphasis on the importance of having the medical record room immediately adjacent to the doctors' lounge and coat room.

The authors have made some excellent points in the chapter covering the ward or nursing unit. They point out forcefully the importance of having adequate utilities, lavatories and toilet space properly spaced so as to minimize nurses' steps and, hence, reduce the time necessary to give good patient care.

The collection of plans from an assorted group of hospitals should be of great interest and the authors have performed a real service in making these available for students of hospital planning.

The authors have not, in connection with the chapter on the surgical unit or in any other section of the book, given adequate consideration to the all important subject of the central sterile supply room. It seems that they could, with great profit to the readers, have included a considerable amount of discussion and typical floor plans for this facility in small, medium and large hospitals. However, the chapter on surgical units is most interesting and comprehensive. Chapters on special departments, such as obstetrics, pediatrics, x-ray and physical therapy, the outpatient department and laboratory service, give a wealth of practical information and interesting plans.

The chapter covering medical school hospitals and allied laboratories is particularly worthy of note and anyone concerned with the planning and operation of the so-called "medical school hospital" will profit from a study of this

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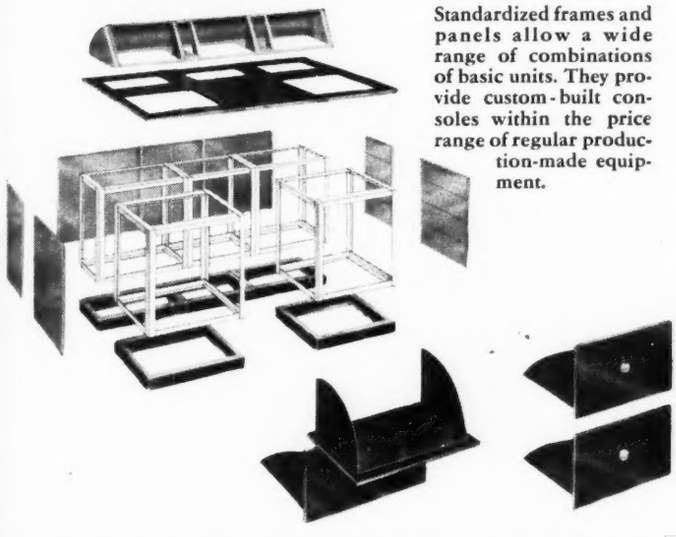

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excellent chapter. The section on the small hospital should be of interest to a large number of people. This section features plans for various types of small hospitals, including several from The Modern Hospital's 1923 competition, as well as the prizewinning plan from a similar competition conducted by The Modern Hospital in 1944.

The section on tuberculosis sanatoriums is complete and should be of real interest to all students of this problem. I believe, however, that the section could have been better had it more completely covered the growing conviction that many tuberculosis cases should be cared for in special tuberculosis departments connected with, or as a part of, general hospitals. The chapter on service buildings gives thoughtful treatment to the problems encountered in laundries, boiler plants and similar service facilities. However, it seems that the section on light, heat and power would have been greatly strengthened had the authors given some attention and pointed out to readers the importance of automatic combustion controls, CO_2 recorders, stack temperature recorders and other boiler room equipment so important to the efficient combustion of fuel.

The chapter on construction and interior finishes is one of the most valuable sections of this splendid book. The authors point out the importance of elimination of noise and give methods of accomplishing this. They emphasize the great importance of damageproof, easily cleaned wainscots in busy areas.

Despite the criticisms offered, it must be pointed out that this comprehensive volume is a splendid piece of work and will no doubt prove to be a classic in hospital literature.—Everett W. Jones.

A Manual for Training Hospital Employes. *By the Cleveland Hospital Council, Cleveland,* 1946.

A survey of the training needs of hospital employes and of ways of meeting those needs has resulted in the publication by the Cleveland Hospital Council of a sound, practical training manual that should be of considerable value to administrators, department heads, supervisors and others charged with the responsibility of training hospital employes.

The study was made by Fenn College under the supervision of the committee on projects of the Cleveland Hospital Council. Funds for the work were provided by a grant from the Cleveland Foundation. Administrators and department heads from member hospitals of the council served on departmental committees and the manual represents the combined thinking and experience of the committee members. Practical employe training technics that have been devised by industry which are capable of adaptation to hospital needs are also incorporated.

The manual, which is divided into three sections, covers two major aspects of employe development: morale and job proficiency. The material is so organized as to give the supervisor who uses it a logical, step-by-step procedure to follow in any given situation.

For example, the opening section on "Development of Morale in Hospital Employes" is divided into three parts: (1) inducting new employes; (2) building good relations; (3) handling strained relations. Each of these topics is covered in a separate section, which, in turn, is broken down into three parts: (1) an introductory statement regarding the importance of the problem; (2) a step-by-step technic suggested for handling the problem, and (3) supplementary background material.

The second section provides the supervisor with methods of analyzing the need for instruction on each job, together with sample training time table and job instruction time table. In addition, it provides a simple way of breaking down jobs and organizing the training by means of job breakdown sheets.

Part 3, which comprises the major portion of the manual, lists job instruc-

tion breakdowns for the seven major departments that account for 70 per cent of hospital employes, *i.e.* administrative, dietary, housekeeping, laundry, maintenance, nursing and procurement. Following general instructions covering the specific procedure, each job is broken down into its most important steps, together with key points to be kept in mind as each step is carried out.

The manual is designed specifically as a source book and teaching guide for supervisors and trainers. It is not intended for self training by the employes.

In the preface, the committee on projects points out that each hospital will necessarily have to adapt the procedures and technics presented to fit its own needs and continues: "They are practical, specific and capable of minimizing the work necessary for getting training under way. . . . This manual is designed to increase the returns on the time and effort invested in the development of employes."

It appears that the "Manual for Training Hospital Employes," if it is used intelligently, should certainly accomplish the purpose of its authors.—JANE BARTON.

NURSING AND NURSING EDUCATION. By *Agnes Gelinas, R.N. New York City: The Commonwealth Fund,* 1946. *Pp.* 72, $1.

"Nursing and Nursing Education" is one of a series of monographs by experts selected by the New York Academy of Medicine Committee on Medicine and the Changing Order.

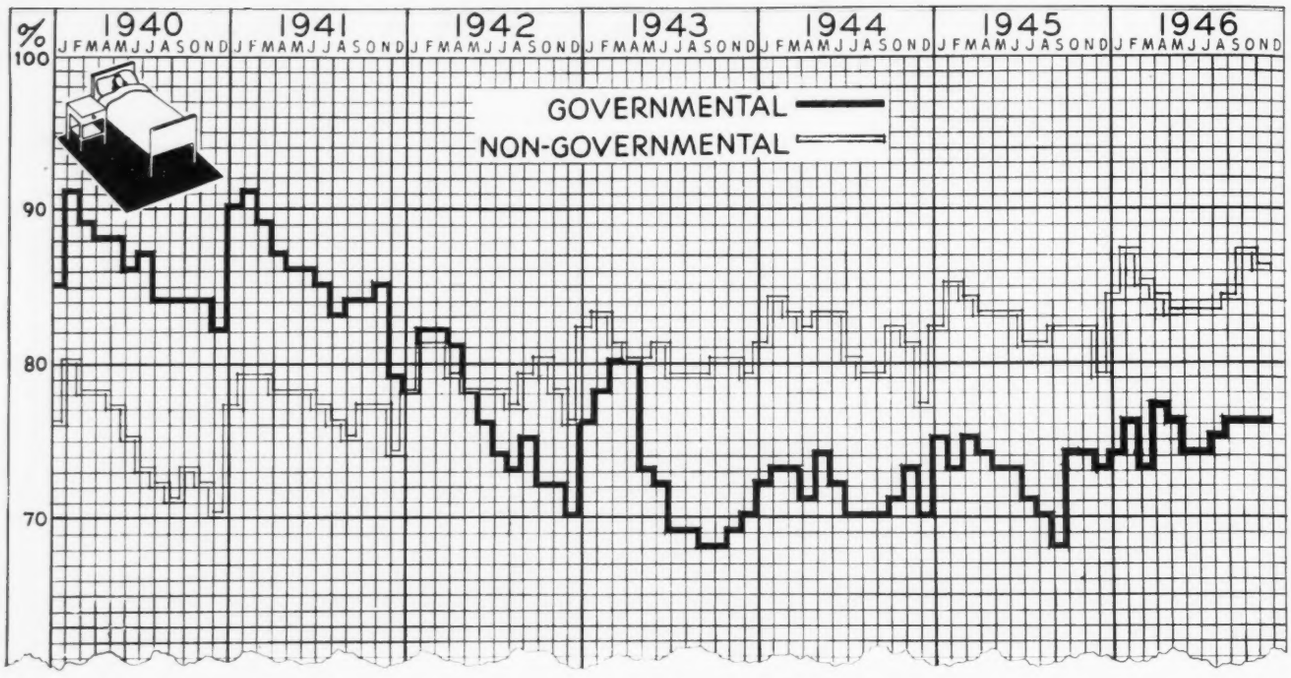
The book consists of a foreword, preface and six chapters with references and supplementary references and an index.

The preface by Mrs. August Belmont emphasizes the rapid growth of nursing as a profession, pays tribute to the quality and effectiveness of nurse leadership and draws attention to the lack of public awareness of the needs and problems of nursing education.

Chapter 1 traces the development of nursing as a profession through the pioneer period, the boom period which followed, on through the period of standard setting and stock taking, concluding with a brief general classification of the broadening fields now open to nurses. Chapter 2 presents up to date statistics on the nursing supply and demand, prewar and wartime, while chapters 3, 4 and 5 deal with personnel policies and standards and nursing education problems. Chapter 6 follows with definite suggestions for the solution of these problems.

The book offers a comprehensive summary of pertinent facts and landmarks in the development of nursing education. Besides being a valuable reference for the nursing library, it is interesting and profitable reading for the lay public.—ELIZABETH W. ODELL, R.N.

Year's Construction Total: $661,426,109



Occupancy of nongovernmental hospitals reporting to the Occupancy Chart for the month of November was 85.7 per cent of capacity, down slightly from the previous month but higher than November a year ago. Nongovernmental hospitals reported occupancy of 76.4 per cent, also less than occupancy in October, and below November 1945.

Construction reported in the last period of the year totaled $189,461,101, substantially the largest period of the year and bringing the year's total to $661,426,109, more than twice the total reported for 1945. Projects for which costs were reported included 62 new hospitals costing $95,765,800; 92 additions costing $42,356,801; three alteration projects averaging $100,000 each, and seven nurses' homes totaling just over $7,000,000.